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HOUSE OF REPRESENTATIVES
REPT. 104–497
Part 1

HEALTH COVERAGE AVAILABILITY AND AFFORDABILITY ACT OF 1996

MARCH 25, 1996.—Ordered to be printed

Mr. BLILEY, from the Committee on Commerce, submitted the following

R E P O R T

together with

MINORITY VIEWS

[To accompany H.R. 3070]

[Including cost estimate of the Congressional Budget Office]

The Committee on Commerce, to whom was referred the bill (H.R. 3070) to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, and to simplify the administration of health insurance, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

CONTENTS

The amendment is as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Health Coverage Availability and Affordability Act of 1996".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—IMPROVED AVAILABILITY AND PORTABILITY OF HEALTH INSURANCE COVERAGE

SUBTITLE A—COVERAGE UNDER GROUP HEALTH PLANS

SEC. 101. PORTABILITY OF COVERAGE FOR PREVIOUSLY COVERED INDIVIDUALS.

(a) CREDITING PERIODS OF PREVIOUS COVERAGE TOWARD PREEXISTING CONDITION RESTRICTIONS.—Subject to the succeeding provisions of this section, a group health plan, and an insurer or health maintenance organization offering health insurance coverage in connection with a group health plan, shall provide that any preexisting condition limitation period (as defined in subsection (b)(2)) is reduced by the length of the aggregate period of qualified prior coverage (if any, as defined in subsection (b)(3)) applicable to the participant or beneficiary as of the date of commencement of coverage under the plan.

(b) DEFINITIONS AND OTHER PROVISIONS RELATING TO PREEXISTING CONDITIONS.—

(1) PREEXISTING CONDITION.—

(A) IN GENERAL.—For purposes of this subtitle, subject to subparagraph (B), the term "preexisting condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the day before—

(i) the effective date of the coverage of such participant or beneficiary, or

(ii) the earliest date upon which such coverage could have been effective if there were no waiting period applicable,

whichever is earlier.

(B) TREATMENT OF GENETIC INFORMATION.—For purposes of this section, genetic information shall not be considered to be a preexisting condition, so long as treatment of the condition to which the information is applicable has not been sought during the 6-month period described in subparagraph (A).

(2) PREEXISTING CONDITION LIMITATION PERIOD.—For purposes of this subtitle, the term "preexisting condition limitation period" means, with respect to coverage of an individual under a group health plan or under health insurance coverage, the period during which benefits with respect to treatment of a condition of such individual are not provided based on the fact that the condition is a preexisting condition.

(3) AGGREGATE PERIOD OF QUALIFIED PRIOR COVERAGE.—

(A) IN GENERAL.—For purposes of this section, the term "aggregate period of qualified prior coverage" means, with respect to commencement of coverage of an individual under a group health plan or health insurance coverage offered in connection with a group health plan, the aggregate of the qualified coverage periods (as defined in subparagraph (B)) of such individual occurring before the date of such commencement. Such period shall be treated as zero if there is more than a 60-day break in coverage under a group health plan (or health insurance coverage offered in connection with

such a plan) between the date the most recent qualified coverage period ends and the date of such commencement.

(B) QUALIFIED COVERAGE PERIOD.—

(i) IN GENERAL.—For purposes of this paragraph, subject to subsection (c), the term ''qualified coverage period'' means, with respect to an individual, any period of coverage of the individual under a group health plan, health insurance coverage, under title XVIII or XIX of the Social Security Act, coverage under the TRICARE program under chapter 55 of title 10, United States Code, a program of the Indian Health Service, and State health insurance coverage or risk pool, and includes coverage under a health plan offered under chapter 89 of title 5, United States Code.

(ii) DISREGARDING PERIODS BEFORE BREAKS IN COVERAGE.—Such term does not include any period occurring before any 60-day break in coverage described in subparagraph (A).

(C) WAITING PERIOD NOT TREATED AS A BREAK IN COVERAGE.—For purposes of subparagraphs (A) and (B), any period that is in a waiting period for any coverage under a group health plan (or for health insurance coverage offered in connection with a group health plan) shall not be considered to be a break in coverage described in subparagraph (B)(ii).

(D) ESTABLISHMENT OF PERIOD.—A qualified coverage period with respect to an individual shall be established through presentation of certifications described in subsection (c) or in such other manner as may be specified in regulations to carry out this section.

(c) CERTIFICATIONS OF COVERAGE; CONFORMING COVERAGE.—

(1) IN GENERAL.—The plan administrator of a group health plan, or the insurer or HMO offering health insurance coverage in connection with a group health plan, shall, on request made on behalf of an individual covered (or previously covered within the previous 18 months) under the plan or coverage, provide for a certification of the period of coverage of the individual under such plan or coverage and of the waiting period (if any) imposed with respect to the individual for any coverage under the plan.

(2) STANDARD METHOD.—Subject to paragraph (3), a group health plan, or insurer or HMO offering health insurance coverage in connection with a group health plan, shall determine qualified coverage periods under subsection (b)(3)(B) by including all periods described in such subsection, without regard to the specific benefits offered during such a period.

(3) ALTERNATIVE METHOD.—Such a plan, insurer, or HMO may elect to make such determination on a benefit-specific basis for all participants and beneficiaries and not to include as a qualified coverage period with respect to a specific benefit coverage during a previous period unless such previous coverage for that benefit was included at the end of the most recent period of coverage. In the case of such an election—

(A) the plan, insurer, or HMO shall prominently state in any disclosure statements concerning the plan or coverage and to each enrollee at the time of enrollment under the plan (or at the time the health insurance coverage is offered for sale in the group health market) that the plan or coverage has made such election and shall include a description of the effect of this election; and

(B) upon the request of the plan, insurer, or HMO, the entity providing a certification under paragraph (1)—

(i) shall promptly disclose to the requesting plan, insurer, or HMO the plan statement (insofar as it relates to health benefits under the plan) or other detailed benefit information on the benefits available under the previous plan or coverage, and

(ii) may charge for the reasonable cost of providing such information.

SEC. 102. LIMITATION ON PREEXISTING CONDITION EXCLUSIONS; NO APPLICATION TO CERTAIN NEWBORNS, ADOPTED CHILDREN, AND PREGNANCY.

(a) LIMITATION OF PERIOD.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, a group health plan, and an insurer or HMO offering health insurance coverage in connection with a group health plan, shall provide that any preexisting condition limitation period (as defined in section 101(b)(2)) does not exceed 12 months, counting from the effective date of coverage.

(2) EXTENSION OF PERIOD IN THE CASE OF LATE ENROLLMENT.—In the case of a participant or beneficiary whose initial coverage commences after the date the participant or beneficiary first becomes eligible for coverage under the group

health plan, the reference in paragraph (1) to "12 months" is deemed a reference to "18 months".

(b) EXCLUSION NOT APPLICABLE TO CERTAIN NEWBORNS AND CERTAIN ADOPTIONS.—

(1) IN GENERAL.—Subject to paragraph (2), a group health plan, and an insurer or HMO offering health insurance coverage in connection with a group health plan, may not provide any limitation on benefits based on the existence of a preexisting condition in the case of—

(A) an individual who within the 30-day period beginning with the date of birth, or

(B) an adopted child or a child placed for adoption beginning at the time of adoption or placement if the individual, within the 30-day period beginning on the date of adoption or placement,

becomes covered under a group health plan or otherwise becomes covered under health insurance coverage (or covered for medical assistance under title XIX of the Social Security Act).

(2) LOSS IF BREAK IN COVERAGE.—Paragraph (1) shall no longer apply to an individual if the individual does not have any coverage described in section 101(b)(3)(B)(i) for a continuous period of 60 days, not counting in such period any days that are in a waiting period for any coverage under a group health plan.

(3) PLACED FOR ADOPTION DEFINED.—In this subsection and section 103(d), the term "placement", or being "placed", for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

(c) EXCLUSION NOT APPLICABLE TO PREGNANCY.—For purposes of this section, pregnancy shall not be treated as a preexisting condition.

(d) ELIGIBILITY PERIOD IMPOSED BY HEALTH MAINTENANCE ORGANIZATIONS AS ALTERNATIVE TO PREEXISTING CONDITION LIMITATION.—A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not use the preexisting condition limitations allowed under this section and section 101 with respect to any particular coverage option may impose an eligibility period for such coverage option, but only if such period does not exceed—

(1) 60 days, in the case of a participant or beneficiary whose initial coverage commences at the time such participant or beneficiary first becomes eligible for coverage under the plan, or

(2) 90 days, in the case of a participant or beneficiary whose initial coverage commences after the date on which such participant or beneficiary first becomes eligible for coverage.

Such an HMO may use alternative methods, from those described in the previous sentence, to address adverse selection as approved by the applicable State authority. For purposes of this subsection, the term "eligibility period" means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. Any such eligibility period shall be treated for purposes of this subtitle as a waiting period under the plan and shall run concurrently with any other applicable waiting period under the plan.

SEC. 103. PROHIBITING EXCLUSIONS BASED ON HEALTH STATUS AND PROVIDING FOR ENROLLMENT PERIODS.

(a) PROHIBITION OF EXCLUSION OF PARTICIPANTS OR BENEFICIARIES BASED ON HEALTH STATUS.—

(1) IN GENERAL.—A group health plan, and an insurer or HMO offering health insurance coverage in connection with a group health plan, may not exclude an employee or his or her beneficiary from being (or continuing to be) a participant or beneficiary under the terms of such plan or coverage based on health status (as defined in section 191(c)(6)).

(2) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the establishment of preexisting condition limitations and restrictions to the extent consistent with the provisions of this subtitle.

(b) ENROLLMENT OF ELIGIBLE INDIVIDUALS WHO LOSE OTHER COVERAGE.—A group health plan shall permit an uncovered employee who is otherwise eligible for coverage under the terms of the plan (or an uncovered dependent, as defined under the terms of the plan, of such an employee, if family coverage is available) to enroll

for coverage under the plan under at least one benefit option if each of the following conditions is met:

(1) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or individual.

(2) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment.

(3) The employee or dependent lost coverage under a group health plan or health insurance coverage (as a result of loss of eligibility for the coverage, termination of employment, or reduction in the number of hours of employment).

(4) The employee requests such enrollment within 30 days after the date of termination of such coverage.

(c) DEPENDENT BENEFICIARIES.—

(1) IN GENERAL.—If a group health plan makes family coverage available, the plan may not require, as a condition of coverage of an individual as a dependent (as defined under the terms of the plan) of a participant in the plan, a waiting period applicable to the coverage of a dependent who—

(A) is a newborn,

(B) is an adopted child or child placed for adoption (within the meaning of section 102(b)(3)), at the time of adoption or placement, or

(C) is a spouse, at the time of marriage,

if the participant has met any waiting period applicable to that participant.

(2) TIMELY ENROLLMENT.—

(A) IN GENERAL.—Enrollment of a participant's beneficiary described in paragraph (1) shall be considered to be timely if a request for enrollment is made within 30 days of the date family coverage is first made available or, in the case described in—

(i) paragraph (1)(A), within 30 days of the date of the birth,

(ii) paragraph (1)(B), within 30 days of the date of the adoption or placement for adoption, or

(iii) paragraph (1)(C), within 30 days of the date of the marriage with such a beneficiary who is the spouse of the participant,

if family coverage is available as of such date.

(B) COVERAGE.—If available coverage includes family coverage and enrollment is made under such coverage on a timely basis under subparagraph (A), the coverage shall become effective not later than the first day of the first month beginning 15 days after the date the completed request for enrollment is received.

SEC. 104. ENFORCEMENT.

(a) ENFORCEMENT THROUGH COBRA PROVISIONS IN INTERNAL REVENUE CODE.—

(1) APPLICATION OF COBRA SANCTIONS.—Subsection (a) of section 4980B of the Internal Revenue Code of 1986 is amended by striking "the requirements of" and all that follows and inserting "the requirements of—

"(1) subsection (f) with respect to any qualified beneficiary, or

"(2) subject to subsection (h)—

"(A) section 101 or 102 of the Health Coverage Availability and Affordability Act of 1996 with respect to any individual covered under the group health plan, or

"(B) section 103 of such Act with respect to any individual.".

(2) NOTICE REQUIREMENT.—Section 4980B(f)(6)(A) of such Code is amended by inserting before the period the following: "and subtitle A of title I of the Health Coverage Availability and Affordability Act of 1996".

(3) SPECIAL RULES.—Section 4980B of such Code is amended by adding at the end the following:

"(h) SPECIAL RULES.—For purposes of applying this section in the case of requirements described in subsection (a)(2) relating to section 101, section 102, or section 103 of the Health Coverage Availability and Affordability Act of 1996—

"(1) DEFERRAL TO STATE REGULATION.—No tax shall be imposed by this section on any failure to meet the requirements of such section by any entity which offers health insurance coverage and which is an insurer or health maintenance organization (as defined in section 191(c) of the Health Coverage Availability and Affordability Act of 1996) regulated by a State if the Secretary of Health and Human Services has made the determination described in section 104(c)(2) of such Act with respect to such State, section, and entity.

"(2) LIMITATION FOR INSURED PLANS.—In the case of a group health plan of a small employer (as defined in section 191 of the Health Coverage Availability

and Affordability Act of 1996) that provides health care benefits solely through a contract with an insurer or health maintenance organization (as defined in such section), no tax shall be imposed by this section upon the employer on a failure to meet such requirements if the failure is solely because of the product offered by the insurer or organization under such contract.

"(3) LIMITATION ON IMPOSITION OF TAX.—In no case shall a tax be imposed by this section for a failure to meet such a requirement if a sanction has been imposed—

"(A) by the Secretary of Labor under part 5 of subtitle A of title I of the Employee Retirement Income Security Act of 1974 with respect to such failure, or

"(B) by the Secretary of Health and Human Services under section 109 of the Health Coverage Availability and Affordability Act of 1996 with respect to such failure.".

(b) ENFORCEMENT THROUGH ERISA SANCTIONS FOR CERTAIN GROUP HEALTH PLANS.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, sections 101 through 103 of this subtitle shall be deemed to be provisions of title I of the Employee Retirement Income Security Act of 1974 for purposes of applying such title.

(2) FEDERAL ENFORCEMENT ONLY IF NO ENFORCEMENT THROUGH STATE.—The Secretary of Labor shall enforce each section referred to in paragraph (1) with respect to any entity which is an insurer or health maintenance organization regulated by a State only if the Secretary of Labor determines that—

(A) such State has not provided for enforcement of State laws which govern the same matters as are governed by such section and which require compliance by such entity with at least the same requirements as those provided under such section, and

(B) such entity has failed to comply with such requirements of such section as are applicable to such entity.

(3) LIMITATIONS ON LIABILITY.—

(A) NO APPLICATION WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No liability shall be imposed under this subsection on the basis of any failure during any period for which it is established to the satisfaction of the Secretary of Labor that none of the persons against whom the liability would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(B) NO APPLICATION WHERE FAILURE CORRECTED WITHIN 30 DAYS.—No liability shall be imposed under this subsection on the basis of any failure if such failure was due to reasonable cause and not to willful neglect, and such failure is corrected during the 30-day period beginning on the first day any of the persons against whom the liability would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(4) AVOIDING DUPLICATION OF CERTAIN PENALTIES.—In no case shall a civil money penalty be imposed under the authority provided under paragraph (1) for a violation of this subtitle for which an excise tax has been imposed under section 4980B of the Internal Revenue Code of 1986 or a civil money penalty imposed under subsection (c).

(c) ENFORCEMENT THROUGH CIVIL MONEY PENALTIES.—

(1) IMPOSITION.—

(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, any group health plan, insurer, or organization that fails to meet a requirement of this subtitle is subject to a civil money penalty under this section.

(B) LIABILITY FOR PENALTY.—Rules similar to the rules described in section 4980B(e) of the Internal Revenue Code of 1986 for liability for a tax imposed under section 4980B(a) of such Code shall apply to liability for a penalty imposed under subparagraph (A).

(C) AMOUNT OF PENALTY.—

(i) IN GENERAL.—The maximum amount of penalty imposed under this paragraph is $100 for each day for each individual with respect to which such a failure occurs.

(ii) CONSIDERATIONS IN IMPOSITION.—In determining the amount of any penalty to be assessed under this paragraph, the Secretary of Health and Human Services shall take into account the previous record of compliance of the person being assessed with the applicable requirements of this subtitle, the gravity of the violation, and the overall limi-

tations for unintentional failures provided under section 4980B(c)(4) of the Internal Revenue Code of 1986.

(iii) LIMITATIONS.—

(I) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No civil money penalty shall be imposed under this paragraph on any failure during any period for which it is established to the satisfaction of the Secretary that none of the persons against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(II) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No civil money penalty shall be imposed under this paragraph on any failure if such failure was due to reasonable cause and not to willful neglect, and such failure is corrected during the 30-day period beginning on the first day any of the persons against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(D) ADMINISTRATIVE REVIEW.—

(i) OPPORTUNITY FOR HEARING.—The person assessed shall be afforded an opportunity for hearing by the Secretary upon request made within 30 days after the date of the issuance of a notice of assessment. In such hearing the decision shall be made on the record pursuant to section 554 of title 5, United States Code. If no hearing is requested, the assessment shall constitute a final and unappealable order.

(ii) HEARING PROCEDURE.—If a hearing is requested, the initial agency decision shall be made by an administrative law judge, and such decision shall become the final order unless the Secretary modifies or vacates the decision. Notice of intent to modify or vacate the decision of the administrative law judge shall be issued to the parties within 30 days after the date of the decision of the judge. A final order which takes effect under this paragraph shall be subject to review only as provided under subparagraph (D).

(E) JUDICIAL REVIEW.—

(i) FILING OF ACTION FOR REVIEW.—Any person against whom an order imposing a civil money penalty has been entered after an agency hearing under this paragraph may obtain review by the United States district court for any district in which such person is located or the United States District Court for the District of Columbia by filing a notice of appeal in such court within 30 days from the date of such order, and simultaneously sending a copy of such notice be registered mail to the Secretary.

(ii) CERTIFICATION OF ADMINISTRATIVE RECORD.—The Secretary shall promptly certify and file in such court the record upon which the penalty was imposed.

(iii) STANDARD FOR REVIEW.—The findings of the Secretary shall be set aside only if found to be unsupported by substantial evidence as provided by section 706(2)(E) of title 5, United States Code.

(iv) APPEAL.—Any final decision, order, or judgment of such district court concerning such review shall be subject to appeal as provided in chapter 83 of title 28 of such Code.

(F) FAILURE TO PAY ASSESSMENT; MAINTENANCE OF ACTION.—

(i) FAILURE TO PAY ASSESSMENT.—If any person fails to pay an assessment after it has become a final and unappealable order, or after the court has entered final judgment in favor of the Secretary, the Secretary shall refer the matter to the Attorney General who shall recover the amount assessed by action in the appropriate United States district court.

(ii) NONREVIEWABILITY.—In such action the validity and appropriateness of the final order imposing the penalty shall not be subject to review.

(G) PAYMENT OF PENALTIES.—Except as otherwise provided, penalties collected under this paragraph shall be paid to the Secretary (or other officer) imposing the penalty and shall be available without appropriation and until expended for the purpose of enforcing the provisions with respect to which the penalty was imposed.

(2) FEDERAL ENFORCEMENT ONLY IF NO ENFORCEMENT THROUGH STATE.—Paragraph (1) shall apply to enforcement of the requirements of section 101, 102, or 103 with respect to any entity which offers health insurance coverage and

which is an insurer or HMO regulated by a State if the Secretary of Health and Human Services has determined that such State has not provided for enforcement of State laws which govern the same matters as are governed by such section and which require compliance by such entity with at least the same requirements as those provided under such section.

(3) NONDUPLICATION OF SANCTIONS.—In no case shall a civil money penalty be imposed under this subsection for a violation of this subtitle for which an excise tax has been imposed under section 4980B of the Internal Revenue Code of 1986 or for which a civil money penalty has been imposed under the authority provided under subsection (b).

(d) COORDINATION IN ADMINISTRATION.—The Secretaries of the Treasury, Labor, and Health and Human Services shall issue regulations that are nonduplicative to carry out this subtitle. Such regulations shall be issued in a manner that assures coordination and nonduplication in their activities under this subtitle.

Subtitle B—Certain Requirements for Insurers and HMOs in the Group and Individual Markets

PART 1—AVAILABILITY OF GROUP HEALTH INSURANCE COVERAGE

SEC. 131. GUARANTEED AVAILABILITY OF GENERAL COVERAGE IN THE SMALL GROUP MARKET.

(a) ISSUANCE OF COVERAGE.—

(1) IN GENERAL.—Subject to the succeeding subsections of this section, each insurer or HMO that offers health insurance coverage in the small group market in a State—

(A) must accept every small employer in the State that applies for such coverage; and

(B) must accept for enrollment under such coverage every eligible individual (as defined in paragraph (2)) who applies for enrollment during the initial period in which the individual first becomes eligible for coverage under the group health plan and may not place any restriction which is inconsistent with section 103(a) on an individual being a participant or beneficiary so long as such individual is an eligible individual.

(2) ELIGIBLE INDIVIDUAL DEFINED.—In this section, the term "eligible individual" means, with respect to an insurer or HMO that offers health insurance coverage to any small employer in the small group market, such an individual in relation to the employer as shall be determined—

(A) in accordance with the terms of such plan,

(B) as provided by the insurer or HMO under rules of the insurer or HMO which are uniformly applicable, and

(C) in accordance with all applicable State laws governing such insurer or HMO.

(b) SPECIAL RULES FOR NETWORK PLANS AND HMOS.—

(1) IN GENERAL.—In the case of an insurer that offers health insurance coverage in the small group market through a network plan and in the case of an HMO that offers health insurance coverage in connection with such a plan, the insurer or HMO may—

(A) limit the employers that may apply for such coverage to those with eligible individuals whose place of employment or residence is in the service area for such plan or HMO;

(B) limit the individuals who may be enrolled under such coverage to those whose place of residence or employment is within the service area for such plan or HMO; and

(C) within the service area of such plan or HMO, deny such coverage to such employers if the insurer or HMO demonstrates that—

(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees, and

(ii) it is applying this paragraph uniformly to all employers without regard to the claims experience of those employers and their employees (and their beneficiaries) or the health status of such employees and beneficiaries.

(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—An insurer or HMO, upon denying health insurance coverage in any service area in accordance with paragraph (1)(C), may not offer coverage in the small group market within such service area for a period of 180 days after such coverage is denied.

(c) SPECIAL RULE FOR FINANCIAL CAPACITY LIMITS.—

(1) IN GENERAL.—An insurer or HMO may deny health insurance coverage in the small group market if the insurer or HMO demonstrates to the applicable State authority that—

(A) it does not have the financial reserves necessary to underwrite additional coverage, and

(B) it is applying this paragraph uniformly to all employers without regard to the claims experience or duration of coverage of those employers and their employees (and their beneficiaries) or the health status of such employees and beneficiaries.

(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—An insurer or HMO upon denying health insurance coverage in connection with group health plans in any service area in accordance with paragraph (1) may not offer coverage in connection with group health plans in the small group market within such service area for a period of 180 days after such coverage is denied.

(d) EXCEPTION TO REQUIREMENT FOR ISSUANCE OF COVERAGE BY REASON OF FAILURE BY PLAN TO MEET CERTAIN MINIMUM PARTICIPATION OR CONTRIBUTION RULES.—

(1) IN GENERAL.—Subsection (a) shall not apply in the case of any group health plan with respect to which—

(A) participation rules of an insurer or HMO which are described in paragraph (2) are not met, or

(B) contribution rules of an insurer or HMO which are described in paragraph (3) are not met.

(2) PARTICIPATION RULES.—For purposes of paragraph (1)(A), participation rules (if any) of an insurer or HMO shall be treated as met with respect to a group health plan only if such rules are uniformly applicable and in accordance with applicable State law and the number or percentage of eligible individuals who, under the plan, are participants or beneficiaries equals or exceeds a level which is determined in accordance with such rules.

(3) CONTRIBUTION RULES.—For purposes of paragraph (1)(B), contribution rules (if any) of an insurer or HMO shall be treated as met with respect to a group health plan only if such rules are in accordance with applicable State law.

SEC. 132. GUARANTEED RENEWABILITY OF GROUP COVERAGE.

(a) IN GENERAL.—Except as provided in this section, if an insurer or health maintenance organization offers health insurance coverage in the small or large group market, the insurer or organization must renew or continue in force such coverage at the option of the employer.

(b) GENERAL EXCEPTIONS.—An insurer or organization may nonrenew or discontinue health insurance coverage offered an employer based only on one or more of the following:

(1) NONPAYMENT OF PREMIUMS.—The employer has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the insurer or organization has not received timely premium payments.

(2) FRAUD.—The employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) VIOLATION WITH PARTICIPATION OR CONTRIBUTION RULES.—The employer has failed to comply with a material plan provision relating to participation or contribution rules in accordance with section 131(d).

(4) TERMINATION OF PLAN.—Subject to subsection (c), the insurer or organization is ceasing to offer coverage in the small or large group market in a State (or, in the case of a network plan or HMO, in a geographic area).

(5) MOVEMENT OUTSIDE SERVICE AREA.—The employer has changed the place of employment in such manner that employees and dependents reside and are employed outside the service area of the insurer or organization or outside the area for which the insurer or organization is authorized to do business.

Paragraph (5) shall apply to an insurer or HMO only if it is applied uniformly without regard to the claims experience of employers and their employees (and their beneficiaries) or the health status of such employees and beneficiaries.

(c) EXCEPTIONS FOR UNIFORM TERMINATION OF COVERAGE.—

(1) PARTICULAR TYPE OF COVERAGE NOT OFFERED.—In any case in which a insurer or HMO decides to discontinue offering a particular type of health insur-

ance coverage in the small or large group market, coverage of such type may be discontinued by the insurer or organization only if—

(A) the insurer or organization provides notice to each employer provided coverage of this type in such market (and participants and beneficiaries covered under such coverage) of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

(B) the insurer or organization offers to each employer in the small employer or large employer market provided coverage of this type, the option to purchase any other health insurance coverage currently being offered by the insurer or organization for employers in such market; and

(C) in exercising the option to discontinue coverage of this type and in offering one or more replacement coverage, the insurer or organization acts uniformly without regard to the health status or insurability of participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

(2) DISCONTINUANCE OF ALL COVERAGE.—

(A) IN GENERAL.—Subject to subparagraph (C), in any case in which an insurer or HMO elects to discontinue offering all health insurance coverage in the small group market or the large group market, or both markets, in a State, health insurance coverage may be discontinued by the insurer or organization only if—

(i) the insurer or organization provides notice to the applicable State authority and to each employer (and participants and beneficiaries covered under such coverage) of such discontinuation at least 180 days prior to the date of the expiration of such coverage, and

(ii) all health insurance issued or delivered for issuance in the State in such market (or markets) are discontinued and coverage under such health insurance coverage in such market (or markets) is not renewed.

(B) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under subparagraph (A) in one or both markets, the insurer or organization may not provide for the issuance of any health insurance coverage in the market and State involved during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) EXCEPTION FOR UNIFORM MODIFICATION OF COVERAGE.—At the time of coverage renewal, an insurer or HMO may modify the coverage offered to a group health plan in the group health market so long as such modification is effective on a uniform basis among group health plans with that type of coverage.

PART 2—AVAILABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE

SEC. 141. GUARANTEED AVAILABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE TO CERTAIN INDIVIDUALS WITH PRIOR GROUP COVERAGE.

(a) GOALS.—The goals of this section are—

(1) to guarantee that any qualifying individual (as defined in subsection (b)(1)) is able to obtain qualifying coverage (as defined in subsection (b)(2)); and

(2) to assure that qualifying individuals obtaining such coverage receive credit for their prior coverage toward the new coverage's preexisting condition exclusion period (if any) in a manner consistent with subsection (b)(3).

(b) QUALIFYING INDIVIDUAL AND HEALTH INSURANCE COVERAGE DEFINED.—In this section—

(1) QUALIFYING INDIVIDUAL.—The term "qualifying individual" means an individual—

(A) who is in a qualified coverage period (as defined in section 101(b)(3)(C)) that—

(i) includes coverage under one or more group health plans, and

(ii) commenced 18 or more months before the date on which the individual seeks coverage under this section;

(B) is not eligible for coverage under (i) a group health plan, (ii) part A or part B of title XVIII of the Social Security Act, or (iii) a State plan under title XIX of such Act (or any successor program);

(C) with respect to whom the most recent coverage within the coverage period described in subparagraph (A)(i) was not terminated based on a factor described in paragraph (1) or (2) of section 132(b);

(D) if the individual had been offered the option of continuation coverage under a COBRA continuation provision or under a similar State program, elected such coverage;

(E) who, if the individual elected such continuation coverage, has exhausted such continuation coverage;

(F) who does not have individual health insurance coverage; and

(G) whose most recent prior coverage either (i) was under a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan), or (ii) was not under such a plan (or such coverage) but was terminated involuntarily because of the withdrawal of the plan or coverage, movement out of a service area, or similar involuntary reasons.

(2) QUALIFYING COVERAGE.—

(A) IN GENERAL.—The term ''qualifying coverage'' means, with respect to an insurer or HMO in relation to an qualifying individual, individual health insurance coverage for which the actuarial value of the benefits is not less than—

(i) the weighted average actuarial value of the benefits provided by all the individual health insurance coverage issued by the insurer or HMO in the State during the previous year (not including coverage issued under this section), or

(ii)the weighted average of the actuarial value of the benefits provided by all the individual health insurance coverage issued by all insurers and HMOs in the State during the previous year (not including coverage issued under this section),

as elected by the plan or by the State under subsection (c)(1).

(B) ASSUMPTIONS.—For purposes of subparagraph (A), the actuarial value of benefits provided under individual health insurance coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

(3) CREDITING FOR PREVIOUS COVERAGE.—Crediting is consistent with this paragraph only if any preexisting condition exclusion period is reduced at least to the extent such a period would be reduced if the coverage under this section were under a group health plan to which section 101(a) applies. In carrying out this subsection, provisions similar to the provisions of section 101(c) shall apply.

(c) OPTIONAL STATE ESTABLISHMENT OF MECHANISMS TO ACHIEVE GOALS OF GUARANTEEING AVAILABILITY OF COVERAGE.—

(1) IN GENERAL.—Any State may establish public or private mechanisms reasonably designed to meet the goals specified in subsection (a). If a State implements such a mechanism by the deadline specified in paragraph (4), the State may elect to have such mechanisms apply instead of having subsection (d) apply in the State. An election under this paragraph shall be by notice to the Secretary of Health and Human Services on a timely basis consistent with the deadlines specified in paragraph (4). In establishing what is qualifying coverage under such a mechanism under this subsection, a State may exercise the election described in subsection (b)(2)(A) with respect to each insurer or HMO in the State (or on a collective basis after exercising such election for each such insurer or HMO).

(2) TYPES OF MECHANISMS.—State mechanisms under this subsection may include one or more (or a combination) of the following:

(A) Health insurance coverage pools or programs authorized or established by the State.

(B) Mandatory group conversion policies.

(C) Guaranteed issue of one or more plans of individual health insurance coverage to qualifying individuals.

(D) Open enrollment by one or more insurers or HMOs.

The mechanisms described in the previous sentence are not an exclusive list of the mechanisms (or combinations of mechanisms) that may be used under this subsection.

(3) SAFE HARBOR FOR BENEFITS UNDER CURRENT RISK POOLS.—In the case of a State that has a health insurance coverage pool or risk pool in effect on March 12, 1996, and that implements the mechanism described in paragraph (2)(A), the benefits under such mechanism (or benefits the actuarial value of which is not less than the actuarial value of such current benefits, using the assumptions described in subsection (b)(2)(B)) are deemed, for purposes of this section, to constitute qualified coverage.

(4) DEADLINE FOR STATE IMPLEMENTATION.—

(A) IN GENERAL.—Subject to subparagraph (B), the deadline under this paragraph is July 1, 1997.

(B) EXTENSION TO PERMIT LEGISLATION.—The deadline under this paragraph is July 1, 1998, in the case of a State the legislature of which does

not have a regular legislative session at any time between January 1, 1997, and June 30, 1997.

(C) CONSTRUCTION.—Nothing in this section shall be construed as preventing a State from—

(i) implementing guaranteed availability mechanisms before the deadline,

(ii) continuing in effect mechanisms that are in effect before the date of the enactment of this Act,

(iii) offering guaranteed availability of coverage that is not qualifying coverage, or

(iv) offering guaranteed availability of coverage to individuals who are not qualifying individuals.

(d) FALLBACK PROVISIONS.—

(1) NO STATE ELECTION.—If a State has not provided notice to the Secretary of an election on a timely basis under subsection (c), the Secretary shall notify the State that paragraph (3) will be applied in the State.

(2) PRELIMINARY DETERMINATION AFTER STATE ELECTION.—If—

(A) a State has provided notice of an election on a timely basis under subsection (c), and

(B) the Secretary finds, after consultation with the chief executive officer of the State and the insurance commissioner or chief insurance regulatory official of the State, that such a mechanism (for which notice was provided) is not reasonably designed to meet the goals specified in subsection (a),

the Secretary shall notify the State of such preliminary determination, of the consequences under paragraph (3) of a failure to implement such a mechanism, and permit the State a reasonable opportunity in which to modify the mechanism (or to adopt another mechanism) that is reasonably designed to meet the goals specified in subsection (a). If, after providing such notice and opportunity, the Secretary finds that the State has not implemented such a mechanism, the Secretary shall notify the State that paragraph (3) will be applied in the State.

(3) DESCRIPTION OF FALLBACK MECHANISM.—As provided under paragraphs (1) and (2) and subject to paragraph (5), each insurer or HMO in the State involved that issues individual health insurance coverage—

(A) shall offer qualifying health insurance coverage, in which qualifying individuals obtaining such coverage receive credit for their prior coverage toward the new coverage's preexisting condition exclusion period (if any) in a manner consistent with subsection (b)(3), to each qualifying individual in the State, and

(B) may not decline to issue such coverage to such an individual based on health status (except as permitted under paragraph (4)).

(4) APPLICATION OF NETWORK AND CAPACITY LIMITS.—Under regulations, the provisions of subsections (b) and (c) of section 131 shall apply to an individual in the individual health insurance market under this subsection in the same manner as they apply under section 131 to an employer in the small group market.

(5) TERMINATION OF FALLBACK MECHANISM.—The provisions of this subsection shall cease to apply to a State if the Secretary finds that a State has implemented a mechanism that is reasonably designed to meet the goals specified in subsection (a), and until the Secretary finds that such mechanism is no longer being implemented.

(e) CONSTRUCTION.—

(1) PREMIUMS.—Nothing in this section shall be construed to affect the determination of an insurer or HMO as to the amount of the premium payable under an individual health insurance coverage under applicable state law.

(2) MARKET REQUIREMENTS.—

(A) IN GENERAL.—The provisions of subsection (a) shall not be construed to require that an insurer or HMO offering health insurance coverage only in connection with a group health plan or an association offer individual health insurance coverage.

(B) CONVERSION POLICIES.—An insurer or HMO offering health insurance coverage in connection with a group health plan under subtitle A shall not be deemed to be an insurer or HMO offering an individual health insurance coverage solely because such insurer or HMO offers a conversion policy.

(3) DISREGARD OF ASSOCIATION COVERAGE.—An insurer or HMO that offers health insurance coverage only in connection with a group health plan or in connection with individuals based on affiliation with one or more associations is not considered, for purposes of this subtitle, to be offering individual health insurance coverage.

(4) MARKETING OF PLANS.—Nothing in this section shall be construed to prevent a State from requiring insurer or HMOs offering individual health insurance coverage to actively market such coverage.

SEC. 142. GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

(a) GUARANTEED RENEWABILITY.—Subject to the succeeding provisions of this section, an insurer or HMO that provides individual health insurance coverage to an individual shall renew or continue such coverage at the option of the individual.

(b) NONRENEWAL PERMITTED IN CERTAIN CASES.—An insurer or HMO may nonrenew or discontinue individual health insurance coverage of an individual only based on one or more of the following:

(1) NONPAYMENT.—The individual fails to pay payment of premiums or contributions in accordance with the terms of the coverage or the insurer or organization has not failed to receive timely premium payments.

(2) FRAUD.—The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) TERMINATION OF COVERAGE.—Subject to subsection (c), the insurer or HMO is ceasing to offer health insurance coverage in the individual market in a State (or, in the case of a network plan or HMO, in a geographic area).

(4) MOVEMENT OUTSIDE SERVICE AREA.—The individual has changed residence and resides outside the service area of the insurer or organization or outside the area for which the insurer or organization is authorized to do business.

Paragraph (4) shall apply to an insurer or HMO only if it is applied uniformly without regard to the claims experience of employers and their employees (and their beneficiaries) or the health status of such employees and beneficiaries.

(c) TERMINATION OF INDIVIDUAL COVERAGE.—The provisions of section 132(c) shall apply to this section in the same manner as they apply under section 132, except that any reference to an employer or market is deemed a reference to a covered individual or the individual market, respectively.

(d) EXCEPTION FOR UNIFORM MODIFICATION OF COVERAGE.—The provisions of section 132(d) shall apply to individual health insurance coverage in the individual market under this section in the same manner as it applies to health insurance coverage offered in connection with a group health plan in the group market under such section.

PART 3—ENFORCEMENT

SEC. 151. INCORPORATION OF PROVISIONS FOR STATE ENFORCEMENT WITH FEDERAL FALLBACK AUTHORITY.

The provisions of paragraphs (1) and (2) of section 104(c) shall apply to enforcement of requirements in each section in part 1 or part 2 with respect to insurers and HMOs regulated by a State in the same manner as such provisions apply to enforcement of requirements in section 101, 102, or 103 with respect to insurers and HMOs regulated by a State.

Subtitle C—Sense of Committee on Additional Requirements

SEC. 161. SENSE OF COMMITTEE ON COMMERCE ON ADDITIONAL REQUIREMENTS.

(a) FINDINGS.—The Committee on Commerce of the House of Representatives finds the following:

(1) The National Cancer Institute has stated that sufficient data do not exist to support widespread clinical applicability of autologous bone marrow transplants and high dosage chemotherapy for treatment of breast cancer.

(2) In relation to mandatory hospital stays for child birth, several studies have shown little association between initial hospital stays and subsequent hospital stays. For example, a review of 20,000 inpatient deliveries found no connection between the length of stay and a newborn's likelihood of developing health problems. Another study that tracked readmission rates to 275,000 discharges showed no statistically significant differences for those who had hospital stays of 24 hours or less.

(b) SENSE OF COMMITTEE.—It is the sense of the Committee on Commerce of the House of Representatives that—

(1) the impact, on health care costs and the provision of necessary quality health services, of mandating the inclusion in health insurance coverage and group health plans of bone marrow transplants for treatment of breast cancer and of minimum periods of inpatient care for child birth has not been evaluated;

(2) there is no legislative precedent for Congress requiring the coverage of specific benefits under private and State health insurance plans; and

(3) it is the intent of the Committee to conduct one or more hearings to examine issues relating to requiring the inclusion of benefits under group health plans and health insurance coverage offered in the group and individual markets.

Subtitle D—Definitions; General Provisions

SEC. 191. DEFINITIONS; SCOPE OF COVERAGE.

(a) GROUP HEALTH PLAN.—

(1) DEFINITION.—Subject to the succeeding provisions of this subsection and subsection (d)(1), the term "group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care (as defined in subsection (c)(9)) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise, and includes a group health plan (within the meaning of section 5000(b)(1) of the Internal Revenue Code of 1986).

(2) LIMITATION OF REQUIREMENTS TO PLANS WITH 2 OR MORE EMPLOYEE PARTICIPANTS.—The requirements of subtitle A and part 1 of subtitle B shall apply in the case of a group health plan for any plan year, or for health insurance coverage offered in connection with a group health plan for a year, only if the group health plan has two or more participants as current employees on the first day of the plan year.

(3) EXCLUSION OF PLANS WITH LIMITED COVERAGE.—An employee welfare benefit plan shall be treated as a group health plan under this title only with respect to medical care which is provided under the plan and which does not consist of coverage excluded from the definition of health insurance coverage under subsection (c)(4)(B).

(4) TREATMENT OF CHURCH PLANS.—

(A) EXCLUSION.—The requirements of this title insofar as they apply to group health plans shall not apply to church plans.

(B) OPTIONAL DISREGARD IN DETERMINING PERIOD OF COVERAGE.—For purposes of applying section 101(b)(3)(B)(i), a group health plan may elect to disregard periods of coverage of an individual under a church plan that, pursuant to subparagraph (A), is not subject to the requirements of this title.

(5) TREATMENT OF GOVERNMENTAL PLANS.—

(A) ELECTION TO BE EXCLUDED.—If the plan sponsor of a governmental plan which is a group health plan to which the provisions of this subtitle otherwise apply makes an election under this paragraph for any specified period (in such form and manner as the Secretary of Health and Human Services may by regulations prescribe), then the requirements of this title insofar as they apply to group health plans shall not apply to such governmental plans for such period.

(B) OPTIONAL DISREGARD IN DETERMINING PERIOD OF COVERAGE IF ELECTION MADE.—For purposes of applying section 101(b)(3)(B)(i), a group health plan may elect to disregard periods of coverage of an individual under a governmental plan that, under an election under subparagraph (A), is not subject to the requirements of this title.

(6) TREATMENT OF MEDICAID PLAN AS GROUP HEALTH PLAN.—A State plan under title XIX of the Social Security Act shall be treated as a group health plan for purposes of applying section 101(c)(1), unless the State elects not to be so treated.

(7) TREATMENT OF MEDICARE AND INDIAN HEALTH SERVICE PROGRAMS AS GROUP HEALTH PLAN.—Title XVIII of the Social Security Act and a program of the Indian Health Service shall be treated as a group health plan for purposes of applying section 101(c)(1).

(b) INCORPORATION OF CERTAIN DEFINITIONS IN EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—Except as provided in this section, the terms "beneficiary", "church plan", "employee", "employee welfare benefit plan", "employer", "governmental plan", "multiemployer plan", "multiple employer welfare arrangement", "par-

ticipant", "plan sponsor", and "State" have the meanings given such terms in section 3 of the Employee Retirement Income Security Act of 1974.

(c) OTHER DEFINITIONS.—For purposes of this title:

(1) APPLICABLE STATE AUTHORITY.—The term "applicable State authority" means, with respect to an insurer or health maintenance organization in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State involved with respect to such insurer or organization.

(2) BONA FIDE ASSOCIATION.—The term "bona fide association" means an association which—

(A) has been actively in existence for at least 5 years,

(B) has been formed and maintained in good faith for purposes other than obtaining insurance,

(C) does not condition membership in the association on health status,

(D) makes health insurance coverage offered through the association available to all members regardless of health status,

(E) does not make health insurance coverage offered through the association available to any individual who is not a member (or dependent of a member) of the association at the time the coverage is initially issued,

(F) does not impose preexisting condition exclusions except in a manner consistent with the requirements of sections 101 and 102 as they relate to group health plans, and

(G) provides for renewal and continuation of health insurance coverage in a manner consistent with the requirements of section 132 as they relate to the renewal and continuation in force of coverage in a group market.

(3) COBRA CONTINUATION PROVISION.—The term "COBRA continuation provision" means any of the following:

(A) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.

(B) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.), other than section 609.

(C) Title XXII of the Public Health Service Act.

(4) HEALTH INSURANCE COVERAGE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term "health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract offered by an insurer or a health maintenance organization.

(B) EXCEPTION.—Such term does not include coverage under any separate policy, certificate, or contract only for one or more of any of the following:

(i) Coverage for accident, credit-only, vision, disability income, long-term care, nursing home care, community-based care dental, on-site medical clinics, or employee assistance programs, or any combination thereof.

(ii) Medicare supplemental health insurance (within the meaning of section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss(g)(1))) and similar supplemental coverage provided under a group health plan.

(iii) Coverage issued as a supplement to liability insurance.

(iv) Liability insurance, including general liability insurance and automobile liability insurance.

(v) Workers' compensation or similar insurance.

(vi) Automobile medical-payment insurance.

(vii) Coverage consisting of benefit payments made on a periodic basis for a specified disease or illness or period of hospitalization, without regard to the costs incurred or services rendered during the period to which the payments relate.

(viii) Short-term limited duration insurance.

(ix) Such other coverage, comparable to that described in previous clauses, as may be specified in regulations prescribed under this title.

(5) HEALTH MAINTENANCE ORGANIZATION; HMO.—The terms "health maintenance organization" and "HMO" mean—

(A) a Federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a))),

(B) an organization recognized under State law as a health maintenance organization, or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization,

if (other than for purposes of part 2 of subtitle B) it is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974).

(6) HEALTH STATUS.—The term "health status" includes, with respect to an individual, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

(7) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term "individual health insurance coverage" means health insurance coverage offered to individuals if the coverage is not offered in connection with a group health plan (other than such a plan that has fewer than two participants as current employees on the first day of the plan year).

(8) INSURER.—The term "insurer" means an insurance company, insurance service, or insurance organization which is licensed to engage in the business of insurance in a State and (except for purposes of part 2 of subtitle B) which is regulated by a State (within the meaning of section 514(b)(2)(A) of the Employee Retirement Income Security Act of 1974).

(9) MEDICAL CARE.—The term "medical care" means—

(A) amounts paid for, or items or services in the form of, the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for, or items or services provided for, the purpose of affecting any structure or function of the body,

(B) amounts paid for, or services in the form of, transportation primarily for and essential to medical care referred to in subparagraph (A), and

(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

(10) NETWORK PLAN.—The term "network plan" means, with respect to health insurance coverage, an arrangement of an insurer or a health maintenance organization under which the financing and delivery of medical care are provided, in whole or in part, through a defined set of providers under contract with the insurer or health maintenance organization.

(11) WAITING PERIOD.—The term "waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the minimum period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the plan.

(d) TREATMENT OF PARTNERSHIPS.—

(1) TREATMENT AS A GROUP HEALTH PLAN.—Any plan, fund, or program which would not be (but for this paragraph) an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that such plan, fund, or program provides medical care to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, shall be treated (subject to paragraph (1)) as an employee welfare benefit plan which is a group health plan.

(2) TREATMENT OF PARTNERSHIP AND PARTNERS AND EMPLOYER AND PARTICIPANTS.—In the case of a group health plan—

(A) the term "employer" includes the partnership in relation to any partner; and

(B) the term "participant" includes—

(i) in connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership, or

(ii) in connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the self-employed individual,

if such individual is or may become eligible to receive a benefit under the plan or such individual's beneficiaries may be eligible to receive any such benefit.

(e) DEFINITIONS RELATING TO MARKETS AND SMALL EMPLOYERS.—As used in this title:

(1) INDIVIDUAL MARKET.—The term "individual market" means the market for health insurance coverage offered to individuals and not to employers or in connection with a group health plan and does not include the market for such coverage issued only by an insurer or HMO that makes such coverage available only on the basis of affiliation with a bona fide association (as defined in subsection (c)(2)).

(2) LARGE GROUP MARKET.—The term "large group market" means the market for health insurance coverage offered to employers (other than small employers) on behalf of their employees (and their dependents) and does not include health insurance coverage available solely in connection with a bona fide association (as defined in subsection (c)(2)).

(3) SMALL EMPLOYER.—The term "small employer" means, in connection with a group health plan with respect to a calendar year, an employer who employs at least 2 but fewer than 51 employees on a typical business day in the year. For purposes of this paragraph, two or more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are within the same control group (within the meaning of section 3(40)(B)(ii)) of the Employee Retirement Income Security Act of 1974.

(4) SMALL GROUP MARKET.—The term "small group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) on the basis of employment or other relationship with respect to a small employer and does not include health insurance coverage available solely in connection with a bona fide association (as defined in subsection (c)(2)).

SEC. 192. STATE FLEXIBILITY TO PROVIDE GREATER PROTECTION.

(a) STATE FLEXIBILITY TO PROVIDE GREATER PROTECTION.—Subject to subsection (b), nothing in this title shall be construed to preempt State laws that require insurers or HMOs—

(1) to impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition for a period that is shorter than the applicable period provided for under this title;

(2) to allow individuals, participants, and beneficiaries to be considered to be in a period of previous qualifying coverage if such individual, participant, or beneficiary experiences a lapse in coverage that is greater than the 60-day periods provided for under sections 101(b)(3)(A), 101(b)(3)(B)(ii), and 102(b)(2); or

(3) in defining "pre-existing condition" to have a look-back period that is shorter than the 6-month period described in section 101(b)(1)(A).

(b) NO OVERRIDE OF ERISA PREEMPTION.—Nothing in this Act shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

SEC. 193. EFFECTIVE DATE.

(a) IN GENERAL.—Except as otherwise provided for in this title, the provisions of this title shall apply with respect to—

(1) group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning on or after January 1, 1998, and

(2) individual health insurance coverage issued, renewed, in effect, or operated on or after July 1, 1998.

(b) CONSIDERATION OF PREVIOUS COVERAGE.—The Secretaries of Health and Human Services, Treasury, and Labor shall jointly establish rules regarding the treatment (in determining qualified coverage periods under sections 102(b) and 141(b)) of coverage before the applicable effective date specified in subsection (a).

(c) TIMELY ISSUANCE OF REGULATIONS.—The Secretaries of Health and Human Services, the Treasury, and Labor shall issue such regulations on a timely basis as may be required to carry out this title.

SEC. 194. RULE OF CONSTRUCTION.

Nothing in this title or any amendment made thereby may be construed to require the coverage of any specific procedure, treatment, or service as part of a group health plan or health insurance coverage under this title or through regulation.

TITLE II—PREVENTING HEALTH CARE FRAUD AND ABUSE; ADMINISTRATIVE SIMPLIFICATION

SEC. 200. REFERENCES IN TITLE.

Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

Subtitle A—Fraud and Abuse Control Program

SEC. 201. FRAUD AND ABUSE CONTROL PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Title XI (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128B the following new section:

"FRAUD AND ABUSE CONTROL PROGRAM

"SEC. 1128C. (a) ESTABLISHMENT OF PROGRAM.—

"(1) IN GENERAL.—Not later than January 1, 1997, the Secretary, acting through the Office of the Inspector General of the Department of Health and Human Services, and the Attorney General shall establish a program—

"(A) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to health plans,

"(B) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States,

"(C) to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B and other statutes applicable to health care fraud and abuse,

"(D) to provide for the modification and establishment of safe harbors and to issue advisory opinions and special fraud alerts pursuant to section 1128D, and

"(E) to provide for the reporting and disclosure of certain final adverse actions against health care providers, suppliers, or practitioners pursuant to the data collection system established under section 1128E.

"(2) COORDINATION WITH HEALTH PLANS.—In carrying out the program established under paragraph (1), the Secretary and the Attorney General shall consult with, and arrange for the sharing of data with representatives of health plans.

"(3) GUIDELINES.—

"(A) IN GENERAL.—The Secretary and the Attorney General shall issue guidelines to carry out the program under paragraph (1). The provisions of sections 553, 556, and 557 of title 5, United States Code, shall not apply in the issuance of such guidelines.

"(B) INFORMATION GUIDELINES.—

"(i) IN GENERAL.—Such guidelines shall include guidelines relating to the furnishing of information by health plans, providers, and others to enable the Secretary and the Attorney General to carry out the program (including coordination with health plans under paragraph (2)).

"(ii) CONFIDENTIALITY.—Such guidelines shall include procedures to assure that such information is provided and utilized in a manner that appropriately protects the confidentiality of the information and the privacy of individuals receiving health care services and items.

"(iii) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) (relating to limitation on liability) shall apply to a person providing information to the Secretary or the Attorney General in conjunction with their performance of duties under this section.

"(4) ENSURING ACCESS TO DOCUMENTATION.—The Inspector General of the Department of Health and Human Services is authorized to exercise such authority described in paragraphs (3) through (9) of section 6 of the Inspector General Act of 1978 (5 U.S.C. App.) as necessary with respect to the activities under the fraud and abuse control program established under this subsection.

"(5) AUTHORITY OF INSPECTOR GENERAL.—Nothing in this Act shall be construed to diminish the authority of any Inspector General, including such authority as provided in the Inspector General Act of 1978 (5 U.S.C. App.).

"(b) ADDITIONAL USE OF FUNDS BY INSPECTOR GENERAL.—

"(1) REIMBURSEMENTS FOR INVESTIGATIONS.—The Inspector General of the Department of Health and Human Services is authorized to receive and retain for current use reimbursement for the costs of conducting investigations and audits and for monitoring compliance plans when such costs are ordered by a court, voluntarily agreed to by the payor, or otherwise.

"(2) CREDITING.—Funds received by the Inspector General under paragraph (1) as reimbursement for costs of conducting investigations shall be deposited to the credit of the appropriation from which initially paid, or to appropriations for similar purposes currently available at the time of deposit, and shall remain available for obligation for 1 year from the date of the deposit of such funds.

"(c) HEALTH PLAN DEFINED.—For purposes of this section, the term 'health plan' means a plan or program that provides health benefits, whether directly, through insurance, or otherwise, and includes—

"(1) a policy of health insurance;

"(2) a contract of a service benefit organization; and

"(3) a membership agreement with a health maintenance organization or other prepaid health plan.".

(b) ESTABLISHMENT OF HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

"(k) HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—

"(1) ESTABLISHMENT.—There is hereby established in the Trust Fund an expenditure account to be known as the 'Health Care Fraud and Abuse Control Account' (in this subsection referred to as the 'Account').

"(2) APPROPRIATED AMOUNTS TO TRUST FUND.—

"(A) IN GENERAL.—There are hereby appropriated to the Trust Fund—

"(i) such gifts and bequests as may be made as provided in subparagraph (B);

"(ii) such amounts as may be deposited in the Trust Fund as provided in sections 242(b) and 249(c) of the Health Coverage Availability and Affordability Act of 1996, and title XI; and

"(iii) such amounts as are transferred to the Trust Fund under subparagraph (C).

"(B) AUTHORIZATION TO ACCEPT GIFTS.—The Trust Fund is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Trust Fund, for the benefit of the Account or any activity financed through the Account.

"(C) TRANSFER OF AMOUNTS.—The Managing Trustee shall transfer to the Trust Fund, under rules similar to the rules in section 9601 of the Internal Revenue Code of 1986, an amount equal to the sum of the following:

"(i) Criminal fines recovered in cases involving a Federal health care offense (as defined in section 982(a)(6)(B) of title 18, United States Code).

"(ii) Civil monetary penalties and assessments imposed in health care cases, including amounts recovered under titles XI, XVIII, and XIX, and chapter 38 of title 31, United States Code (except as otherwise provided by law).

"(iii) Amounts resulting from the forfeiture of property by reason of a Federal health care offense.

"(iv) Penalties and damages obtained and otherwise creditable to miscellaneous receipts of the general fund of the Treasury obtained under sections 3729 through 3733 of title 31, United States Code (known as the False Claims Act), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

"(3) APPROPRIATED AMOUNTS TO ACCOUNT FOR FRAUD AND ABUSE CONTROL PROGRAM, ETC.—

"(A) DEPARTMENTS OF HEALTH AND HUMAN SERVICES AND JUSTICE.—

"(i) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund such sums as the Secretary and the Attorney General certify are necessary to carry out the purposes described in subparagraph (C), to be available without further appropriation, in an amount not to exceed—

"(I) for fiscal year 1997, $104,000,000,

"(II) for each of the fiscal years 1998 through 2003, the limit for the preceding fiscal year, increased by 15 percent; and

"(III) for each fiscal year after fiscal year 2003, the limit for fiscal year 2003.

"(ii) MEDICARE AND MEDICAID ACTIVITIES.—For each fiscal year, of the amount appropriated in clause (i), the following amounts shall be available only for the purposes of the activities of the Office of the Inspector General of the Department of Health and Human Services with respect to the medicare and medicaid programs—

"(I) for fiscal year 1997, not less than $60,000,000 and not more than $70,000,000;

"(II) for fiscal year 1998, not less than $80,000,000 and not more than $90,000,000;

"(III) for fiscal year 1999, not less than $90,000,000 and not more than $100,000,000;

"(IV) for fiscal year 2000, not less than $110,000,000 and not more than $120,000,000;

"(V) for fiscal year 2001, not less than $120,000,000 and not more than $130,000,000;

"(VI) for fiscal year 2002, not less than $140,000,000 and not more than $150,000,000; and

"(VII) for each fiscal year after fiscal year 2002, not less than $150,000,000 and not more than $160,000,000.

"(B) FEDERAL BUREAU OF INVESTIGATION.—There are hereby appropriated from the general fund of the United States Treasury and hereby appropriated to the Account for transfer to the Federal Bureau of Investigation to carry out the purposes described in subparagraph (C), to be available without further appropriation—

"(i) for fiscal year 1997, $47,000,000;

"(ii) for fiscal year 1998, $56,000,000;

"(iii) for fiscal year 1999, $66,000,000;

"(iv) for fiscal year 2000, $76,000,000;

"(v) for fiscal year 2001, $88,000,000;

"(vi) for fiscal year 2002, $101,000,000; and

"(vii) for each fiscal year after fiscal year 2002, $114,000,000.

"(C) USE OF FUNDS.—The purposes described in this subparagraph are to cover the costs (including equipment, salaries and benefits, and travel and training) of the administration and operation of the health care fraud and abuse control program established under section 1128C(a), including the costs of—

"(i) prosecuting health care matters (through criminal, civil, and administrative proceedings);

"(ii) investigations;

"(iii) financial and performance audits of health care programs and operations;

"(iv) inspections and other evaluations; and

"(v) provider and consumer education regarding compliance with the provisions of title XI.

"(4) APPROPRIATED AMOUNTS TO ACCOUNT FOR MEDICARE INTEGRITY PROGRAM.—

"(A) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund for each fiscal year such amounts as are necessary to carry out the Medicare Integrity Program under section 1893, subject to subparagraph (B) and to be available without further appropriation.

"(B) AMOUNTS SPECIFIED.—The amount appropriated under subparagraph (A) for a fiscal year is as follows:

"(i) For fiscal year 1997, such amount shall be not less than $430,000,000 and not more than $440,000,000.

"(ii) For fiscal year 1998, such amount shall be not less than $490,000,000 and not more than $500,000,000.

"(iii) For fiscal year 1999, such amount shall be not less than $550,000,000 and not more than $560,000,000.

"(iv) For fiscal year 2000, such amount shall be not less than $620,000,000 and not more than $630,000,000.

"(v) For fiscal year 2001, such amount shall be not less than $670,000,000 and not more than $680,000,000.

"(vi) For fiscal year 2002, such amount shall be not less than $690,000,000 and not more than $700,000,000.

"(vii) For each fiscal year after fiscal year 2002, such amount shall be not less than $710,000,000 and not more than $720,000,000.

"(5) ANNUAL REPORT.—The Secretary and the Attorney General shall submit jointly an annual report to Congress on the amount of revenue which is generated and disbursed, and the justification for such disbursements, by the Account in each fiscal year.".

SEC. 202. MEDICARE INTEGRITY PROGRAM.

(a) ESTABLISHMENT OF MEDICARE INTEGRITY PROGRAM.—Title XVIII is amended by adding at the end the following new section:

"MEDICARE INTEGRITY PROGRAM

"SEC. 1893. (a) ESTABLISHMENT OF PROGRAM.—There is hereby established the Medicare Integrity Program (in this section referred to as the 'Program') under which the Secretary shall promote the integrity of the medicare program by entering into contracts in accordance with this section with eligible private entities to carry out the activities described in subsection (b).

"(b) ACTIVITIES DESCRIBED.—The activities described in this subsection are as follows:

"(1) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies used in the review of claims under this title as of the date of the enactment of this section).

"(2) Audit of cost reports.

"(3) Determinations as to whether payment should not be, or should not have been, made under this title by reason of section 1862(b), and recovery of payments that should not have been made.

"(4) Education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

"(5) Developing (and periodically updating) a list of items of durable medical equipment in accordance with section 1834(a)(15) which are subject to prior authorization under such section.

"(c) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if—

"(1) the entity has demonstrated capability to carry out such activities;

"(2) in carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General of the United States, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this title and in other cases arising out of such activities;

"(3) the entity demonstrates to the Secretary that the entity's financial holdings, interests, or relationships will not interfere with its ability to perform the functions to be required by the contract in an effective and impartial manner; and

"(4) the entity meets such other requirements as the Secretary may impose.

In the case of the activity described in subsection (b)(5), an entity shall be deemed to be eligible to enter into a contract under the Program to carry out the activity if the entity is a carrier with a contract in effect under section 1842.

"(d) PROCESS FOR ENTERING INTO CONTRACTS.—The Secretary shall enter into contracts under the Program in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

"(1) The Secretary shall determine the appropriate number of separate contracts which are necessary to carry out the Program and the appropriate times at which the Secretary shall enter into such contracts.

"(2)(A) Except as provided in subparagraph (B), the provisions of section 1153(e)(1) shall apply to contracts and contracting authority under this section.

"(B) Competitive procedures must be used when entering into new contracts under this section, or at any other time considered appropriate by the Secretary, except that the Secretary may contract with entities that are carrying out the activities described in this section pursuant to agreements under section 1816 or contracts under section 1842 in effect on the date of the enactment of this section.

"(3) A contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

"(e) LIMITATION ON CONTRACTOR LIABILITY.—The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1157.".

(b) ELIMINATION OF FI AND CARRIER RESPONSIBILITY FOR CARRYING OUT ACTIVITIES SUBJECT TO PROGRAM.—

(1) RESPONSIBILITIES OF FISCAL INTERMEDIARIES UNDER PART A.—Section 1816 (42 U.S.C. 1395h) is amended by adding at the end the following new subsection:

"(l) No agency or organization may carry out (or receive payment for carrying out) any activity pursuant to an agreement under this section to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893.".

(2) RESPONSIBILITIES OF CARRIERS UNDER PART B.—Section 1842(c) (42 U.S.C. 1395u(c)) is amended by adding at the end the following new paragraph:

"(6) No carrier may carry out (or receive payment for carrying out) any activity pursuant to a contract under this subsection to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).".

SEC. 203. BENEFICIARY INCENTIVE PROGRAMS.

(a) CLARIFICATION OF REQUIREMENT TO PROVIDE EXPLANATION OF MEDICARE BENEFITS.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall provide an explanation of benefits under the medicare program under title XVIII of the Social Security Act with respect to each item or service for which payment may be made under the program which is furnished to an individual, without regard to whether or not a deductible or coinsurance may be imposed against the individual with respect to the item or service.

(b) PROGRAM TO COLLECT INFORMATION ON FRAUD AND ABUSE.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary shall establish a program under which the Secretary shall encourage individuals to report to the Secretary information on individuals and entities who are engaging or who have engaged in acts or omissions which constitute grounds for the imposition of a sanction under section 1128, section 1128A, or section 1128B of the Social Security Act, or who have otherwise engaged in fraud and abuse against the medicare program for which there is a sanction provided under law. The program shall discourage provision of, and not consider, information which is frivolous or otherwise not relevant or material to the imposition of such a sanction.

(2) PAYMENT OF PORTION OF AMOUNTS COLLECTED.—If an individual reports information to the Secretary under the program established under paragraph (1) which serves as the basis for the collection by the Secretary or the Attorney General of any amount of at least $100 (other than any amount paid as a penalty under section 1128B of the Social Security Act), the Secretary may pay a portion of the amount collected to the individual (under procedures similar to those applicable under section 7623 of the Internal Revenue Code of 1986 to payments to individuals providing information on violations of such Code).

(c) PROGRAM TO COLLECT INFORMATION ON PROGRAM EFFICIENCY.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary shall establish a program under which the Secretary shall encourage individuals to submit to the Secretary suggestions on methods to improve the efficiency of the medicare program.

(2) PAYMENT OF PORTION OF PROGRAM SAVINGS.—If an individual submits a suggestion to the Secretary under the program established under paragraph (1) which is adopted by the Secretary and which results in savings to the program, the Secretary may make a payment to the individual of such amount as the Secretary considers appropriate.

SEC. 204. APPLICATION OF CERTAIN HEALTH ANTI-FRAUD AND ABUSE SANCTIONS TO FRAUD AND ABUSE AGAINST FEDERAL HEALTH CARE PROGRAMS.

(a) IN GENERAL.—Section 1128B (42 U.S.C. 1320a–7b) is amended as follows:

(1) In the heading, by striking "MEDICARE OR STATE HEALTH CARE PROGRAMS" and inserting "FEDERAL HEALTH CARE PROGRAMS".

(2) In subsection (a)(1), by striking "a program under title XVIII or a State health care program (as defined in section 1128(h))" and inserting "a Federal health care program".

(3) In subsection (a)(5), by striking "a program under title XVIII or a State health care program" and inserting "a Federal health care program".

(4) In the second sentence of subsection (a)—

(A) by striking "a State plan approved under title XIX" and inserting "a Federal health care program", and

(B) by striking "the State may at its option (notwithstanding any other provision of that title or of such plan)" and inserting "the administrator of

such program may at its option (notwithstanding any other provision of such program)".

(5) In subsection (b), by striking "title XVIII or a State health care program" each place it appears and inserting "a Federal health care program".

(6) In subsection (c), by inserting "(as defined in section 1128(h))" after "a State health care program".

(7) By adding at the end the following new subsection:

"(f) For purposes of this section, the term 'Federal health care program' means—

"(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5, United States Code); or

"(2) any State health care program, as defined in section 1128(h).".

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1997.

SEC. 205. GUIDANCE REGARDING APPLICATION OF HEALTH CARE FRAUD AND ABUSE SANCTIONS.

Title XI (42 U.S.C. 1301 et seq.), as amended by section 201, is amended by inserting after section 1128C the following new section:

"GUIDANCE REGARDING APPLICATION OF HEALTH CARE FRAUD AND ABUSE SANCTIONS

"SEC. 1128D. (a) SOLICITATION AND PUBLICATION OF MODIFICATIONS TO EXISTING SAFE HARBORS AND NEW SAFE HARBORS.—

"(1) IN GENERAL.—

"(A) SOLICITATION OF PROPOSALS FOR SAFE HARBORS.—Not later than January 1, 1997, and not less than annually thereafter, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for—

"(i) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987 (42 U.S.C. 1320a–7b note);

"(ii) additional safe harbors specifying payment practices that shall not be treated as a criminal offense under section 1128B(b) and shall not serve as the basis for an exclusion under section 1128(b)(7);

"(iii) advisory opinions to be issued pursuant to subsection (b); and

"(iv) special fraud alerts to be issued pursuant to subsection (c).

"(B) PUBLICATION OF PROPOSED MODIFICATIONS AND PROPOSED ADDITIONAL SAFE HARBORS.—After considering the proposals described in clauses (i) and (ii) of subparagraph (A), the Secretary, in consultation with the Attorney General, shall publish in the Federal Register proposed modifications to existing safe harbors and proposed additional safe harbors, if appropriate, with a 60-day comment period. After considering any public comments received during this period, the Secretary shall issue final rules modifying the existing safe harbors and establishing new safe harbors, as appropriate.

"(C) REPORT.—The Inspector General of the Department of Health and Human Services (in this section referred to as the 'Inspector General') shall, in an annual report to Congress or as part of the year-end semiannual report required by section 5 of the Inspector General Act of 1978 (5 U.S.C. App.), describe the proposals received under clauses (i) and (ii) of subparagraph (A) and explain which proposals were included in the publication described in subparagraph (B), which proposals were not included in that publication, and the reasons for the rejection of the proposals that were not included.

"(2) CRITERIA FOR MODIFYING AND ESTABLISHING SAFE HARBORS.—In modifying and establishing safe harbors under paragraph (1)(B), the Secretary may consider the extent to which providing a safe harbor for the specified payment practice may result in any of the following:

"(A) An increase or decrease in access to health care services.

"(B) An increase or decrease in the quality of health care services.

"(C) An increase or decrease in patient freedom of choice among health care providers.

"(D) An increase or decrease in competition among health care providers.

"(E) An increase or decrease in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

"(F) An increase or decrease in the cost to Federal health care programs (as defined in section 1128B(f)).

"(G) An increase or decrease in the potential overutilization of health care services.

"(H) The existence or nonexistence of any potential financial benefit to a health care professional or provider which may vary based on their decisions of—

"(i) whether to order a health care item or service; or

"(ii) whether to arrange for a referral of health care items or services to a particular practitioner or provider.

"(I) Any other factors the Secretary deems appropriate in the interest of preventing fraud and abuse in Federal health care programs (as so defined).

"(b) ADVISORY OPINIONS.—

"(1) ISSUANCE OF ADVISORY OPINIONS.—The Secretary shall issue written advisory opinions as provided in this subsection.

"(2) MATTERS SUBJECT TO ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as to the following matters:

"(A) What constitutes prohibited remuneration within the meaning of section 1128B(b).

"(B) Whether an arrangement or proposed arrangement satisfies the criteria set forth in section 1128B(b)(3) for activities which do not result in prohibited remuneration.

"(C) Whether an arrangement or proposed arrangement satisfies the criteria which the Secretary has established, or shall establish by regulation for activities which do not result in prohibited remuneration.

"(D) What constitutes an inducement to reduce or limit services to individuals entitled to benefits under title XVIII or title XIX or title XXI within the meaning of section 1128B(b).

"(E) Whether any activity or proposed activity constitutes grounds for the imposition of a sanction under section 1128, 1128A, or 1128B.

"(3) MATTERS NOT SUBJECT TO ADVISORY OPINIONS.—Such advisory opinions shall not address the following matters:

"(A) Whether the fair market value shall be, or was paid or received for any goods, services or property.

"(B) Whether an individual is a bona fide employee within the requirements of section 3121(d)(2) of the Internal Revenue Code of 1986.

"(4) EFFECT OF ADVISORY OPINIONS.—

"(A) BINDING AS TO SECRETARY AND PARTIES INVOLVED.—Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

"(B) FAILURE TO SEEK OPINION.—The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of sections 1128, 1128A, or 1128B.

"(5) REGULATIONS.—

"(A) IN GENERAL.—Not later than 180 days after the date of the enactment of this section, the Secretary shall issue regulations to carry out this section. Such regulations shall provide for—

"(i) the procedure to be followed by a party applying for an advisory opinion;

"(ii) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

"(iii) the interval in which the Secretary shall respond;

"(iv) the reasonable fee to be charged to the party requesting an advisory opinion; and

"(v) the manner in which advisory opinions will be made available to the public.

"(B) SPECIFIC CONTENTS.—Under the regulations promulgated pursuant to subparagraph (A)—

"(i) the Secretary shall be required to respond to a party requesting an advisory opinion by not later than 30 days after the request is received; and

"(ii) the fee charged to the party requesting an advisory opinion shall be equal to the costs incurred by the Secretary in responding to the request.

"(c) SPECIAL FRAUD ALERTS.—

"(1) IN GENERAL.—

"(A) REQUEST FOR SPECIAL FRAUD ALERTS.—Any person may present, at any time, a request to the Inspector General for a notice which informs the public of practices which the Inspector General considers to be suspect or of particular concern under the medicare program or a State health care

program, as defined in section 1128(h) (in this subsection referred to as a 'special fraud alert').

"(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—Upon receipt of a request described in subparagraph (A), the Inspector General shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Inspector General shall issue a special fraud alert in response to the request. All special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

"(2) CRITERIA FOR SPECIAL FRAUD ALERTS.—In determining whether to issue a special fraud alert upon a request described in paragraph (1), the Inspector General may consider—

"(A) whether and to what extent the practices that would be identified in the special fraud alert may result in any of the consequences described in subsection (a)(2); and

"(B) the volume and frequency of the conduct that would be identified in the special fraud alert.".

Subtitle B—Revisions to Current Sanctions for Fraud and Abuse

SEC. 211. MANDATORY EXCLUSION FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) INDIVIDUAL CONVICTED OF FELONY RELATING TO HEALTH CARE FRAUD.—

(1) IN GENERAL.—Section 1128(a) (42 U.S.C. 1320a–7(a)) is amended by adding at the end the following new paragraph:

"(3) FELONY CONVICTION RELATING TO HEALTH CARE FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.".

(2) CONFORMING AMENDMENT.—Paragraph (1) of section 1128(b) (42 U.S.C. 1320a–7(b)) is amended to read as follows:

"(1) CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, under Federal or State law—

"(A) of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct—

"(i) in connection with the delivery of a health care item or service, or

"(ii) with respect to any act or omission in a health care program (other than those specifically described in subsection (a)(1)) operated by or financed in whole or in part by any Federal, State, or local government agency; or

"(B) of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency.".

(b) INDIVIDUAL CONVICTED OF FELONY RELATING TO CONTROLLED SUBSTANCE.—

(1) IN GENERAL.—Section 1128(a) (42 U.S.C. 1320a–7(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

"(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.".

(2) CONFORMING AMENDMENT.—Section 1128(b)(3) (42 U.S.C. 1320a–7(b)(3)) is amended—

(A) in the heading, by striking "CONVICTION" and inserting "MISDEMEANOR CONVICTION"; and

(B) by striking "criminal offense" and inserting "criminal offense consisting of a misdemeanor".

SEC. 212. ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is amended by adding at the end the following new subparagraphs:

"(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

"(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

"(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.".

SEC. 213. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH OWNERSHIP OR CONTROL INTEREST IN SANCTIONED ENTITIES.

Section 1128(b) (42 U.S.C. 1320a–7(b)) is amended by adding at the end the following new paragraph:

"(15) INDIVIDUALS CONTROLLING A SANCTIONED ENTITY.—(A) Any individual—

"(i) who has a direct or indirect ownership or control interest in a sanctioned entity and who knows or should know (as defined in section 1128A(i)(6)) of the action constituting the basis for the conviction or exclusion described in subparagraph (B); or

"(ii) who is an officer or managing employee (as defined in section 1126(b)) of such an entity.

"(B) For purposes of subparagraph (A), the term 'sanctioned entity' means an entity—

"(i) that has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection; or

"(ii) that has been excluded from participation under a program under title XVIII or under a State health care program.".

SEC. 214. SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.

(a) MINIMUM PERIOD OF EXCLUSION FOR PRACTITIONERS AND PERSONS FAILING TO MEET STATUTORY OBLIGATIONS.—

(1) IN GENERAL.—The second sentence of section 1156(b)(1) (42 U.S.C. 1320c–5(b)(1)) is amended by striking "may prescribe)" and inserting "may prescribe, except that such period may not be less than 1 year)".

(2) CONFORMING AMENDMENT.—Section 1156(b)(2) (42 U.S.C. 1320c–5(b)(2)) is amended by striking "shall remain" and inserting "shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain".

(b) REPEAL OF "UNWILLING OR UNABLE" CONDITION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1) (42 U.S.C. 1320c–5(b)(1)) is amended—

(1) in the second sentence, by striking "and determines" and all that follows through "such obligations,"; and

(2) by striking the third sentence.

SEC. 215. INTERMEDIATE SANCTIONS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

(a) APPLICATION OF INTERMEDIATE SANCTIONS FOR ANY PROGRAM VIOLATIONS.—

(1) IN GENERAL.—Section 1876(i)(1) (42 U.S.C. 1395mm(i)(1)) is amended by striking "the Secretary may terminate" and all that follows and inserting "in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—

"(A) has failed substantially to carry out the contract;

"(B) is carrying out the contract in a manner substantially inconsistent with the efficient and effective administration of this section; or

"(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).".

(2) OTHER INTERMEDIATE SANCTIONS FOR MISCELLANEOUS PROGRAM VIOLATIONS.—Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is amended by adding at the end the following new subparagraph:

"(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1) the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

"(i) Civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

"(ii) Civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists.

"(iii) Suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.".

(3) PROCEDURES FOR IMPOSING SANCTIONS.—Section 1876(i) (42 U.S.C. 1395mm(i)) is amended by adding at the end the following new paragraph:

"(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

"(A) the Secretary first provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1) and the organization fails to develop or implement such a plan;

"(B) in deciding whether to impose sanctions, the Secretary considers aggravating factors such as whether an organization has a history of deficiencies or has not taken action to correct deficiencies the Secretary has brought to the organization's attention;

"(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

"(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.".

(4) CONFORMING AMENDMENTS.—Section 1876(i)(6)(B) (42 U.S.C. 1395mm(i)(6)(B)) is amended by striking the second sentence.

(b) AGREEMENTS WITH PEER REVIEW ORGANIZATIONS.—Section 1876(i)(7)(A) (42 U.S.C. 1395mm(i)(7)(A)) is amended by striking "an agreement" and inserting "a written agreement".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on or after January 1, 1996.

SEC. 216. ADDITIONAL EXCEPTION TO ANTI-KICKBACK PENALTIES FOR DISCOUNTING AND MANAGED CARE ARRANGEMENTS.

(a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

(1) by striking "and" at the end of subparagraph (D);

(2) by striking the period at the end of subparagraph (E) and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(F) any remuneration between an organization and an individual or entity providing items or services, or a combination thereof, pursuant to a written agreement between the organization and the individual or entity if the organization is an eligible organization under section 1876 or if the written agreement places the individual or entity at substantial financial risk for the cost or utilization of the items or services, or a combination thereof, which the individual or entity is obligated to provide, whether through a withhold, capitation, incentive pool, per diem payment, or any other similar risk arrangement which places the individual or entity at substantial financial risk.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to written agreements entered into on or after January 1, 1997.

SEC. 217. CRIMINAL PENALTY FOR FRAUDULENT DISPOSITION OF ASSETS IN ORDER TO OBTAIN MEDICAID BENEFITS.

Section 1128B(a) (42 U.S.C. 1320a–7b(a)) is amended—

(1) by striking "or" at the end of paragraph (4);
(2) by adding "or" at the end of paragraph (5); and
(3) by inserting after paragraph (5) the following new paragraph:

"(6) knowingly and willfully disposes of assets (including by any transfer in trust) in order for an individual to become eligible for medical assistance under a State plan under title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c),".

SEC. 218. EFFECTIVE DATE.

Except as otherwise provided, the amendments made by this subtitle shall take effect January 1, 1997.

Subtitle C—Data Collection

SEC. 221. ESTABLISHMENT OF THE HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM.

(a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.), as amended by sections 201 and 205, is amended by inserting after section 1128D the following new section:

"HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM

"SEC. 1128E. (a) GENERAL PURPOSE.—Not later than January 1, 1997, the Secretary shall establish a national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (c).

"(b) REPORTING OF INFORMATION.—

"(1) IN GENERAL.—Each Government agency and health plan shall report any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner.

"(2) INFORMATION TO BE REPORTED.—The information to be reported under paragraph (1) includes:

"(A) The name and TIN (as defined in section 7701(a)(41) of the Internal Revenue Code of 1986) of any health care provider, supplier, or practitioner who is the subject of a final adverse action.

"(B) The name (if known) of any health care entity with which a health care provider, supplier, or practitioner is affiliated or associated.

"(C) The nature of the final adverse action and whether such action is on appeal.

"(D) A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the Secretary determines by regulation is required for appropriate interpretation of information reported under this section.

"(3) CONFIDENTIALITY.—In determining what information is required, the Secretary shall include procedures to assure that the privacy of individuals receiving health care services is appropriately protected.

"(4) TIMING AND FORM OF REPORTING.—The information required to be reported under this subsection shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be required to be reported on a date specified by the Secretary.

"(5) TO WHOM REPORTED.—The information required to be reported under this subsection shall be reported to the Secretary.

"(c) DISCLOSURE AND CORRECTION OF INFORMATION.—

"(1) DISCLOSURE.—With respect to the information about final adverse actions (not including settlements in which no findings of liability have been made) reported to the Secretary under this section respecting a health care provider, supplier, or practitioner, the Secretary shall, by regulation, provide for—

"(A) disclosure of the information, upon request, to the health care provider, supplier, or licensed practitioner, and

"(B) procedures in the case of disputed accuracy of the information.

"(2) CORRECTIONS.—Each Government agency and health plan shall report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, in such form and manner that the Secretary prescribes by regulation.

"(d) ACCESS TO REPORTED INFORMATION.—

"(1) AVAILABILITY.—The information in this database shall be available to Federal and State government agencies and health plans pursuant to procedures that the Secretary shall provide by regulation.

"(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information in this database (other than with respect to requests by Federal agencies). The amount of such a fee shall be sufficient to recover the full costs of operating the database. Such fees shall be available to the Secretary or, in the Secretary's discretion to the agency designated under this section to cover such costs.

"(e) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity, including the agency designated by the Secretary in subsection (b)(5) shall be held liable in any civil action with respect to any report made as required by this section, without knowledge of the falsity of the information contained in the report.

"(f) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

"(1) FINAL ADVERSE ACTION.—

"(A) IN GENERAL.—The term 'final adverse action' includes:

"(i) Civil judgments against a health care provider, supplier, or practitioner in Federal or State court related to the delivery of a health care item or service.

"(ii) Federal or State criminal convictions related to the delivery of a health care item or service.

"(iii) Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including—

"(I) formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation,

"(II) any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or

"(III) any other negative action or finding by such Federal or State agency that is publicly available information.

"(iv) Exclusion from participation in Federal or State health care programs.

"(v) Any other adjudicated actions or decisions that the Secretary shall establish by regulation.

"(B) EXCEPTION.—The term does not include any action with respect to a malpractice claim.

"(2) PRACTITIONER.—The terms 'licensed health care practitioner', 'licensed practitioner', and 'practitioner' mean, with respect to a State, an individual who is licensed or otherwise authorized by the State to provide health care services (or any individual who, without authority holds himself or herself out to be so licensed or authorized).

"(3) GOVERNMENT AGENCY.—The term 'Government agency' shall include:

"(A) The Department of Justice.

"(B) The Department of Health and Human Services.

"(C) Any other Federal agency that either administers or provides payment for the delivery of health care services, including, but not limited to the Department of Defense and the Veterans' Administration.

"(D) State law enforcement agencies.

"(E) State medicaid fraud control units.

"(F) Federal or State agencies responsible for the licensing and certification of health care providers and licensed health care practitioners.

"(4) HEALTH PLAN.—The term 'health plan' has the meaning given such term by section 1128C(c).

"(5) DETERMINATION OF CONVICTION.—For purposes of paragraph (1), the existence of a conviction shall be determined under paragraph (4) of section 1128(i).".

(b) IMPROVED PREVENTION IN ISSUANCE OF MEDICARE PROVIDER NUMBERS.—Section 1842(r) (42 U.S.C. 1395u(r)) is amended by adding at the end the following new sentence: "Under such system, the Secretary may impose appropriate fees on such physicians to cover the costs of investigation and recertification activities with respect to the issuance of the identifiers.".

Subtitle D—Civil Monetary Penalties

SEC. 231. SOCIAL SECURITY ACT CIVIL MONETARY PENALTIES.

(a) GENERAL CIVIL MONETARY PENALTIES.—Section 1128A (42 U.S.C. 1320a–7a) is amended as follows:

(1) In the third sentence of subsection (a), by striking "programs under title XVIII" and inserting "Federal health care programs (as defined in section 1128B(f)(1))".

(2) In subsection (f)—

(A) by redesignating paragraph (3) as paragraph (4); and

(B) by inserting after paragraph (2) the following new paragraph:

"(3) With respect to amounts recovered arising out of a claim under a Federal health care program (as defined in section 1128B(f)), the portion of such amounts as is determined to have been paid by the program shall be repaid to the program, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by the Health Coverage Availability and Affordability Act of 1996 (as estimated by the Secretary) shall be deposited into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C).".

(3) In subsection (i)—

(A) in paragraph (2), by striking "title V, XVIII, XIX, or XX of this Act" and inserting "a Federal health care program (as defined in section 1128B(f))",

(B) in paragraph (4), by striking "a health insurance or medical services program under title XVIII or XIX of this Act" and inserting "a Federal health care program (as so defined)", and

(C) in paragraph (5), by striking "title V, XVIII, XIX, or XX" and inserting "a Federal health care program (as so defined)".

(4) By adding at the end the following new subsection:

"(m)(1) For purposes of this section, with respect to a Federal health care program not contained in this Act, references to the Secretary in this section shall be deemed to be references to the Secretary or Administrator of the department or agency with jurisdiction over such program and references to the Inspector General of the Department of Health and Human Services in this section shall be deemed to be references to the Inspector General of the applicable department or agency.

"(2)(A) The Secretary and Administrator of the departments and agencies referred to in paragraph (1) may include in any action pursuant to this section, claims within the jurisdiction of other Federal departments or agencies as long as the following conditions are satisfied:

"(i) The case involves primarily claims submitted to the Federal health care programs of the department or agency initiating the action.

"(ii) The Secretary or Administrator of the department or agency initiating the action gives notice and an opportunity to participate in the investigation to the Inspector General of the department or agency with primary jurisdiction over the Federal health care programs to which the claims were submitted.

"(B) If the conditions specified in subparagraph (A) are fulfilled, the Inspector General of the department or agency initiating the action is authorized to exercise all powers granted under the Inspector General Act of 1978 with respect to the claims submitted to the other departments or agencies to the same manner and extent as provided in that Act with respect to claims submitted to such departments or agencies.".

(b) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP OR CONTROL INTEREST IN PARTICIPATING ENTITY.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(1) by striking "or" at the end of paragraph (1)(D);

(2) by striking ", or" at the end of paragraph (2) and inserting a semicolon;

(3) by striking the semicolon at the end of paragraph (3) and inserting "; or"; and

(4) by inserting after paragraph (3) the following new paragraph:

"(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII or a State health care program in accordance with this subsection or under section 1128 and who, at the time of a violation of this subsection—

"(A) retains a direct or indirect ownership or control interest in an entity that is participating in a program under title XVIII or a State health care program, and who knows or should know of the action constituting the basis for the exclusion; or

"(B) is an officer or managing employee (as defined in section 1126(b)) of such an entity;".

(c) MODIFICATIONS OF AMOUNTS OF PENALTIES AND ASSESSMENTS.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by subsection (b), is amended in the matter following paragraph (4)—

(1) by striking "$2,000" and inserting "$10,000";

(2) by inserting "; in cases under paragraph (4), $10,000 for each day the prohibited relationship occurs" after "false or misleading information was given"; and

(3) by striking "twice the amount" and inserting "3 times the amount".

(d) CLAIM FOR ITEM OR SERVICE BASED ON INCORRECT CODING OR MEDICALLY UNNECESSARY SERVICES.—Section 1128A(a)(1) (42 U.S.C. 1320a–7a(a)(1)) is amended—

(1) in subparagraph (A) by striking "claimed," and inserting "claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided,";

(2) in subparagraph (C), by striking "or" at the end; and

(3) by inserting after subparagraph (D) the following new subparagraph:

"(E) is for a medical or other item or service that a person knows or should know is not medically necessary; or".

(e) SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.—Section 1156(b)(3) (42 U.S.C. 1320c–5(b)(3)) is amended by striking "the actual or estimated cost" and inserting "up to $10,000 for each instance".

(f) PROCEDURAL PROVISIONS.—Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)), as amended by section 215(a)(2), is amended by adding at the end the following new subparagraph:

"(D) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (B)(i) or (C)(i) in the same manner as such provisions apply to a civil money penalty or proceeding under section 1128A(a).".

(g) PROHIBITION AGAINST OFFERING INDUCEMENTS TO INDIVIDUALS ENROLLED UNDER PROGRAMS OR PLANS.—

(1) OFFER OF REMUNERATION.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended, is amended—

(A) by striking "or" at the end of paragraph (3);

(B) by striking the semicolon at the end of paragraph (4) and inserting "; or"; and

(D) by inserting after paragraph (4) the following new paragraph:

"(5) offers to or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program (as so defined);".

(2) REMUNERATION DEFINED.—Section 1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by adding at the end the following new paragraph:

"(6) The term 'remuneration' includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term 'remuneration' does not include—

"(A) the waiver of coinsurance and deductible amounts by a person, if—

"(i) the waiver is not offered as part of any advertisement or solicitation;

"(ii) the person does not routinely waive coinsurance or deductible amounts; and

"(iii) the person—

"(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need;

"(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or

"(III) provides for any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary;

"(B) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all beneficiaries, third party payers, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in

regulations promulgated by the Secretary not later than 180 days after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996; or

"(C) incentives given to individuals to promote the delivery of preventive care as determined by the Secretary in regulations so promulgated.".

(h) EFFECTIVE DATE.—The amendments made by this section shall take effect January 1, 1997.

SEC. 232. CLARIFICATION OF LEVEL OF INTENT REQUIRED FOR IMPOSITION OF SANCTIONS.

(a) CLARIFICATION OF LEVEL OF KNOWLEDGE REQUIRED FOR IMPOSITION OF CIVIL MONETARY PENALTIES.—

(1) IN GENERAL.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(A) in paragraphs (1) and (2), by inserting "knowingly" before "presents" each place it appears; and

(B) in paragraph (3), by striking "gives" and inserting "knowingly gives or causes to be given".

(2) DEFINITION OF STANDARD.—Section 1128A(i) (42 U.S.C. 1320a–7a(i)), as amended by section 231(g)(2), is amended by adding at the end the following new paragraph:

"(7) The term 'should know' means that a person, with respect to information—

"(A) acts in deliberate ignorance of the truth or falsity of the information; or

"(B) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to acts or omissions occurring on or after January 1, 1997.

SEC. 233. PENALTY FOR FALSE CERTIFICATION FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1128A(b) (42 U.S.C. 1320a–7a(b)) is amended by adding at the end the following new paragraph:

"(3)(A) Any physician who executes a document described in subparagraph (B) with respect to an individual knowing that all of the requirements referred to in such subparagraph are not met with respect to the individual shall be subject to a civil monetary penalty of not more than the greater of—

"(i) $5,000, or

"(ii) three times the amount of the payments under title XVIII for home health services which are made pursuant to such certification.

"(B) A document described in this subparagraph is any document that certifies, for purposes of title XVIII, that an individual meets the requirements of section 1814(a)(2)(C) or 1835(a)(2)(A) in the case of home health services furnished to the individual.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to certifications made on or after the date of the enactment of this Act.

Subtitle E—Revisions to Criminal Law

SEC. 241. DEFINITION OF FEDERAL HEALTH CARE OFFENSE.

(a) IN GENERAL.—Chapter 1 of title 18, United States Code, is amended by adding at the end the following:

"§ 24. Definition of Federal health care offense

"(a) As used in this title, the term 'Federal health care offense' means a violation of, or a criminal conspiracy to violate—

"(1) section 669, 1035, or 1347 of this title; or

"(2) section 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of this title, if the violation or conspiracy relates to a health care benefit program.

"(b) As used in this title, the term 'health care benefit program' has the meaning given such term in section 1347(b) of this title.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 2 of title 18, United States Code, is amended by inserting after the item relating to section 23 the following new item:

"24. Definition of Federal health care offense.".

SEC. 242. HEALTH CARE FRAUD.

(a) OFFENSE.—

(1) IN GENERAL.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"§ 1347. Health care fraud

"(a) Whoever knowingly executes, or attempts to execute, a scheme or artifice—

"(1) to defraud any health care benefit program; or

"(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program,

in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365 of this title), such person shall be fined under this title or imprisoned not more than 20 years, or both; and if the violation results in death, such person shall be fined under this title, or imprisoned for any term of years or for life, or both.

"(b) As used in this section, the term 'health care benefit program' means any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract.".

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"1347. Health care fraud.".

(b) CRIMINAL FINES DEPOSITED IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—The Secretary of the Treasury shall deposit into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C) of the Social Security Act (42 U.S.C. 1395i) an amount equal to the criminal fines imposed under section 1347 of title 18, United States Code (relating to health care fraud).

SEC. 243. THEFT OR EMBEZZLEMENT.

(a) IN GENERAL.—Chapter 31 of title 18, United States Code, is amended by adding at the end the following:

"§ 669. Theft or embezzlement in connection with health care

"(a) Whoever embezzles, steals, or otherwise without authority willfully and unlawfully converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health care benefit program, shall be fined under this title or imprisoned not more than 10 years, or both; but if the value of such property does not exceed the sum of $100 the defendant shall be fined under this title or imprisoned not more than one year, or both.

"(b) As used in this section, the term 'health care benefit program' has the meaning given such term in section 1347(b) of this title.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 31 of title 18, United States Code, is amended by adding at the end the following:

"669. Theft or embezzlement in connection with health care.".

SEC. 244. FALSE STATEMENTS.

(a) IN GENERAL.—Chapter 47 of title 18, United States Code, is amended by adding at the end the following:

"§ 1035. False statements relating to health care matters

"(a) Whoever, in any matter involving a health care benefit program, knowingly—

"(1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or

"(2) makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry,

in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 5 years, or both.

"(b) As used in this section, the term 'health care benefit program' has the meaning given such term in section 1347(b) of this title.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 47 of title 18, United States Code, is amended by adding at the end the following new item:

"1035. False statements relating to health care matters.".

SEC. 245. OBSTRUCTION OF CRIMINAL INVESTIGATIONS OF HEALTH CARE OFFENSES.

(a) IN GENERAL.—Chapter 73 of title 18, United States Code, is amended by adding at the end the following:

"§ 1518. Obstruction of criminal investigations of health care offenses

"(a) Whoever willfully prevents, obstructs, misleads, delays or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of a Federal health care offense to a criminal investigator shall be fined under this title or imprisoned not more than 5 years, or both.

"(b) As used in this section the term 'criminal investigator' means any individual duly authorized by a department, agency, or armed force of the United States to conduct or engage in investigations for prosecutions for violations of health care offenses.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 of title 18, United States Code, is amended by adding at the end the following new item:

"1518. Obstruction of criminal investigations of health care offenses.".

SEC. 246. LAUNDERING OF MONETARY INSTRUMENTS.

Section 1956(c)(7) of title 18, United States Code, is amended by adding at the end the following:

"(F) Any act or activity constituting an offense involving a Federal health care offense.".

SEC. 247. INJUNCTIVE RELIEF RELATING TO HEALTH CARE OFFENSES.

(a) IN GENERAL.—Section 1345(a)(1) of title 18, United States Code, is amended—

(1) by striking "or" at the end of subparagraph (A);

(2) by inserting "or" at the end of subparagraph (B); and

(3) by adding at the end the following:

"(C) committing or about to commit a Federal health care offense.".

(b) FREEZING OF ASSETS.—Section 1345(a)(2) of title 18, United States Code, is amended by inserting "or a Federal health care offense" after "title)".

SEC. 248. AUTHORIZED INVESTIGATIVE DEMAND PROCEDURES.

(a) IN GENERAL.—Chapter 223 of title 18, United States Code, is amended by adding after section 3485 the following:

"§ 3486. Authorized investigative demand procedures

"(a) AUTHORIZATION.—In any investigation relating to any act or activity involving a Federal health care offense, the Attorney General or the Attorney General's designee may issue in writing and cause to be served a subpoena requiring the production of any records (including any books, papers, documents, electronic media, or other objects or tangible things), which may be relevant to an authorized law enforcement inquiry, that a person or legal entity may possess or have care, custody, or control. A subpoena shall describe the objects required to be produced and prescribe a return date within a reasonable period of time within which the objects can be assembled and made available.

"(b) SERVICE.—A subpoena issued under this section may be served by any person designated in the subpoena to serve it. Service upon a natural person may be made by personal delivery of the subpoena to him. Service may be made upon a domestic or foreign corporation or upon a partnership or other unincorporated association which is subject to suit under a common name, by delivering the subpoena to an officer, to a managing or general agent, or to any other agent authorized by appointment or by law to receive service of process. The affidavit of the person serving the subpoena entered on a true copy thereof by the person serving it shall be proof of service.

"(c) ENFORCEMENT.—In the case of contumacy by or refusal to obey a subpoena issued to any person, the Attorney General may invoke the aid of any court of the United States within the jurisdiction of which the investigation is carried on or of which the subpoenaed person is an inhabitant, or in which he carries on business or may be found, to compel compliance with the subpoena. The court may issue an order requiring the subpoenaed person to appear before the Attorney General to produce records, if so ordered, or to give testimony touching the matter under investigation. Any failure to obey the order of the court may be punished by the court as a contempt thereof. All process in any such case may be served in any judicial district in which such person may be found.

"(d) IMMUNITY FROM CIVIL LIABILITY.—Notwithstanding any Federal, State, or local law, any person, including officers, agents, and employees, receiving a summons under this section, who complies in good faith with the summons and thus

produces the materials sought, shall not be liable in any court of any State or the United States to any customer or other person for such production or for nondisclosure of that production to the customer.

"(e) LIMITATION ON USE.—(1) Health information about an individual that is disclosed under this section may not be used in, or disclosed to any person for use in, any administrative, civil, or criminal action or investigation directed against the individual who is the subject of the information unless the action or investigation arises out of and is directly related to receipt of health care or payment for health care or action involving a fraudulent claim related to health; or if authorized by an appropriate order of a court of competent jurisdiction, granted after application showing good cause therefor.

"(2) In assessing good cause, the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services.

"(3) Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 223 of title 18, United States Code, is amended by inserting after the item relating to section 3485 the following new item:

"3486. Authorized investigative demand procedures.".

(c) CONFORMING AMENDMENT.—Section 1510(b)(3)(B) of title 18, United States Code, is amended by inserting "or a Department of Justice subpoena (issued under section 3486 of title 18)," after "subpoena".

SEC. 249. FORFEITURES FOR FEDERAL HEALTH CARE OFFENSES.

(a) IN GENERAL.—Section 982(a) of title 18, United States Code, is amended by adding after paragraph (5) the following new paragraph:

"(6) The court, in imposing sentence on a person convicted of a Federal health care offense, shall order the person to forfeit property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.".

(b) CONFORMING AMENDMENT.—Section 982(b)(1)(A) of title 18, United States Code, is amended by inserting "or (a)(6)" after "(a)(1)".

(c) PROPERTY FORFEITED DEPOSITED IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—

(1) IN GENERAL.—After the payment of the costs of asset forfeiture has been made, and notwithstanding any other provision of law, the Secretary of the Treasury shall deposit into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C) of the Social Security Act, as added by section 301(b), an amount equal to the net amount realized from the forfeiture of property by reason of a Federal health care offense pursuant to section 982(a)(6) of title 18, United States Code.

(2) COSTS OF ASSET FORFEITURE.—For purposes of paragraph (1), the term "payment of the costs of asset forfeiture" means—

(A) the payment, at the discretion of the Attorney General, of any expenses necessary to seize, detain, inventory, safeguard, maintain, advertise, sell, or dispose of property under seizure, detention, or forfeited, or of any other necessary expenses incident to the seizure, detention, forfeiture, or disposal of such property, including payment for—

(i) contract services,

(ii) the employment of outside contractors to operate and manage properties or provide other specialized services necessary to dispose of such properties in an effort to maximize the return from such properties; and

(iii) reimbursement of any Federal, State, or local agency for any expenditures made to perform the functions described in this subparagraph;

(B) at the discretion of the Attorney General, the payment of awards for information or assistance leading to a civil or criminal forfeiture involving any Federal agency participating in the Health Care Fraud and Abuse Control Account;

(C) the compromise and payment of valid liens and mortgages against property that has been forfeited, subject to the discretion of the Attorney General to determine the validity of any such lien or mortgage and the amount of payment to be made, and the employment of attorneys and other personnel skilled in State real estate law as necessary;

(D) payment authorized in connection with remission or mitigation procedures relating to property forfeited; and

(E) the payment of State and local property taxes on forfeited real property that accrued between the date of the violation giving rise to the forfeiture and the date of the forfeiture order.

Subtitle F—Administrative Simplification

SEC. 251. PURPOSE.

It is the purpose of this subtitle to improve the medicare program under title XVIII of the Social Security Act, the medicaid program under title XIX of such Act, and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information.

SEC. 252. ADMINISTRATIVE SIMPLIFICATION.

(a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.) is amended by adding at the end the following:

"PART C—ADMINISTRATIVE SIMPLIFICATION

"SEC. 1171. DEFINITIONS.

"For purposes of this part:

"(1) CLEARINGHOUSE.—The term 'clearinghouse' means a public or private entity that—

"(A) processes or facilitates the processing of nonstandard data elements of health information into standard data elements; or

"(B) provides the means by which persons may meet the requirements of this part.

"(2) CODE SET.—The term 'code set' means any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

"(3) HEALTH CARE PROVIDER.—The term 'health care provider' includes a provider of services (as defined in section 1861(u)), a provider of medical or other health services (as defined in section 1861(s)), and any other person furnishing health care services or supplies.

"(4) HEALTH INFORMATION.—The term 'health information' means any information, whether oral or recorded in any form or medium that—

"(A) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or clearinghouse; and

"(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

"(5) HEALTH PLAN.—The term 'health plan' means a plan which provides, or pays the cost of, health benefits. Such term includes the following, or any combination thereof:

"(A) Part A or part B of the medicare program under title XVIII.

"(B) The medicaid program under title XIX.

"(C) A medicare supplemental policy (as defined in section 1882(g)(1)).

"(D) Coverage issued as a supplement to liability insurance.

"(E) General liability insurance.

"(F) Worker's compensation or similar insurance.

"(G) Automobile or automobile medical-payment insurance.

"(H) A long-term care policy, including a nursing home fixed indemnity policy (unless the Secretary determines that such a policy does not provide sufficiently comprehensive coverage of a benefit so that the policy should be treated as a health plan).

"(I) A hospital or fixed indemnity income-protection policy.

"(J) An employee welfare benefit plan, as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(1)), but only to the extent the plan is established or maintained for the purpose of providing health benefits and has 50 or more participants (as defined in section 3(7) of such Act).

"(K) An employee welfare benefit plan or any other arrangement which is established or maintained for the purpose of offering or providing health benefits to the employees of 2 or more employers.

"(L) The health care program for active military personnel under title 10, United States Code.

"(M) The veterans health care program under chapter 17 of title 38, United States Code.

"(N) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in section 1073(4) of title 10, United States Code.

"(O) The Indian health service program under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

"(P) The Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code.

"(Q) Such other plan or arrangement as the Secretary determines is a health plan.

"(6) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term 'individually identifiable health information' means any information, including demographic information collected from an individual, that—

"(A) is created or received by a health care provider, health plan, employer, or clearinghouse; and

"(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and—

"(i) identifies the individual; or

"(ii) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

"(7) STANDARD.—The term 'standard', when used with reference to a data element of health information or a transaction referred to in section 1173(a)(1), means any such data element or transaction that meets each of the standards and implementation specifications adopted or established by the Secretary with respect to the data element or transaction under sections 1172 through 1174.

"(8) STANDARD SETTING ORGANIZATION.—The term 'standard setting organization' means a standard setting organization accredited by the American National Standards Institute, including the National Council for Prescription Drug Programs, that develops standards for information transactions, data elements, or any other standard that is necessary to, or will facilitate, the implementation of this part.

"SEC. 1172. GENERAL REQUIREMENTS FOR ADOPTION OF STANDARDS.

"(a) APPLICABILITY.—Any standard adopted under this part shall apply to the following persons:

"(1) A health plan.

"(2) A clearinghouse.

"(3) A health care provider who transmits any health information in electronic form in connection with a transaction referred to in section 1173(a)(1).

"(b) REDUCTION OF COSTS.—Any standard adopted under this part shall be consistent with the objective of reducing the administrative costs of providing and paying for health care.

"(c) ROLE OF STANDARD SETTING ORGANIZATIONS.—

"(1) IN GENERAL.—Except as provided in paragraph (2), any standard adopted under this part shall be developed or modified by a standard setting organization.

"(2) SPECIAL RULES.—

"(A) DIFFERENT STANDARDS.—The Secretary may adopt a standard that is different from any standard developed or modified by a standard setting organization, if—

"(i) the different standard will substantially reduce administrative costs to health care providers and health plans compared to the alternatives; and

"(ii) the standard is promulgated in accordance with the rulemaking procedures of subchapter III of chapter 5 of title 5, United States Code.

"(B) NO STANDARD BY STANDARD SETTING ORGANIZATION.—If no standard setting organization has adopted or modified any standard relating to a standard that the Secretary is authorized or required to adopt under this part—

"(i) paragraph (1) shall not apply; and

"(ii) subsection (f) shall apply.

"(d) IMPLEMENTATION SPECIFICATIONS.—The Secretary shall establish specifications for implementing each of the standards adopted under this part.

"(e) PROTECTION OF TRADE SECRETS.—Except as otherwise required by law, a standard adopted under this part shall not require disclosure of trade secrets or confidential commercial information by a person required to comply with this part.

"(f) ASSISTANCE TO THE SECRETARY.—In complying with the requirements of this part, the Secretary shall rely on the recommendations of the Health Information Advisory Committee established under section 1179 and shall consult with appropriate Federal and State agencies and private organizations. The Secretary shall publish in the Federal Register the recommendations of the Health Information Advisory Committee regarding the adoption of a standard under this part.

"(g) APPLICATION TO MODIFICATIONS OF STANDARDS.—This section shall apply to a modification to a standard (including an addition to a standard) adopted under section 1174(b) in the same manner as it applies to an initial standard adopted under section 1174(a).

"SEC. 1173. STANDARDS FOR INFORMATION TRANSACTIONS AND DATA ELEMENTS.

"(a) STANDARDS TO ENABLE ELECTRONIC EXCHANGE.—

"(1) IN GENERAL.—The Secretary shall adopt standards for transactions, and data elements for such transactions, to enable health information to be exchanged electronically, that are—

"(A) appropriate for the financial and administrative transactions described in paragraph (2); and

"(B) related to other financial and administrative transactions determined appropriate by the Secretary consistent with the goals of improving the operation of the health care system and reducing administrative costs.

"(2) TRANSACTIONS.—The transactions referred to in paragraph (1)(A) are the following:

"(A) Claims (including coordination of benefits) or equivalent encounter information.

"(B) Claims attachments.

"(C) Enrollment and disenrollment.

"(D) Eligibility.

"(E) Health care payment and remittance advice.

"(F) Premium payments.

"(G) First report of injury.

"(H) Claims status.

"(I) Referral certification and authorization.

"(3) ACCOMMODATION OF SPECIFIC PROVIDERS.—The standards adopted by the Secretary under paragraph (1) shall accommodate the needs of different types of health care providers.

"(b) UNIQUE HEALTH IDENTIFIERS.—

"(1) IN GENERAL.—The Secretary shall adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system. In carrying out the preceding sentence for each health plan and health care provider, the Secretary shall take into account multiple uses for identifiers and multiple locations and specialty classifications for health care providers.

"(2) USE OF IDENTIFIERS.—The standards adopted under paragraphs (1) shall specify the purposes for which a unique health identifier may be used.

"(c) CODE SETS.—

"(1) IN GENERAL.—The Secretary shall adopt standards that—

"(A) select code sets for appropriate data elements for the transactions referred to in subsection (a)(1) from among the code sets that have been developed by private and public entities; or

"(B) establish code sets for such data elements if no code sets for the data elements have been developed.

"(2) DISTRIBUTION.—The Secretary shall establish efficient and low-cost procedures for distribution (including electronic distribution) of code sets and modifications made to such code sets under section 1174(b).

"(d) SECURITY STANDARDS FOR HEALTH INFORMATION.—

"(1) SECURITY STANDARDS.—The Secretary shall adopt security standards that—

"(A) take into account—

"(i) the technical capabilities of record systems used to maintain health information;

"(ii) the costs of security measures;

"(iii) the need for training persons who have access to health information;

"(iv) the value of audit trails in computerized record systems; and

"(v) the needs and capabilities of small health care providers and rural health care providers (as such providers are defined by the Secretary); and

"(B) ensure that a clearinghouse, if it is part of a larger organization, has policies and security procedures which isolate the activities of the clearinghouse with respect to processing information in a manner that prevents unauthorized access to such information by such larger organization.

"(2) SAFEGUARDS.—Each person described in section 1172(a) who maintains or transmits health information shall maintain reasonable and appropriate administrative, technical, and physical safeguards—

"(A) to ensure the integrity and confidentiality of the information;

"(B) to protect against any reasonably anticipated—

"(i) threats or hazards to the security or integrity of the information; and

"(ii) unauthorized uses or disclosures of the information; and

"(C) otherwise to ensure compliance with this part by the officers and employees of such person.

"(e) PRIVACY STANDARDS FOR HEALTH INFORMATION.—The Secretary shall adopt standards with respect to the privacy of individually identifiable health information. Such standards shall include standards concerning at least the following:

"(1) The rights of an individual who is a subject of such information.

"(2) The procedures to be established for the exercise of such rights.

"(3) The uses and disclosures of such information that are authorized or required.

"(f) ELECTRONIC SIGNATURE.—

"(1) IN GENERAL.—The Secretary, in coordination with the Secretary of Commerce, shall adopt standards specifying procedures for the electronic transmission and authentication of signatures, compliance with which shall be deemed to satisfy Federal and State statutory requirements for written signatures with respect to the transactions referred to in subsection (a)(1).

"(2) PAYMENTS FOR SERVICES AND PREMIUMS.—Nothing in this part shall be construed to prohibit payment for health care services or health plan premiums by debit, credit, payment card or numbers, or other electronic means.

"(g) TRANSFER OF INFORMATION AMONG HEALTH PLANS.—The Secretary shall adopt standards for transferring among health plans appropriate standard data elements needed for the coordination of benefits, the sequential processing of claims, and other data elements for individuals who have more than one health plan.

"SEC. 1174. TIMETABLES FOR ADOPTION OF STANDARDS.

"(a) INITIAL STANDARDS.—The Secretary shall carry out section 1173 not later than 18 months after the date of the enactment of this part, except that standards relating to claims attachments shall be adopted not later than 30 months after such date.

"(b) ADDITIONS AND MODIFICATIONS TO STANDARDS.—

"(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall review the standards adopted under section 1173, and shall adopt modifications to the standards (including additions to the standards), as determined appropriate, but not more frequently than once every 6 months. Any addition or modification to a standard shall be completed in a manner which minimizes the disruption and cost of compliance.

"(2) SPECIAL RULES.—

"(A) FIRST 12-MONTH PERIOD.—Except with respect to additions and modifications to code sets under subparagraph (B), the Secretary may not adopt any modification to a standard adopted under this part during the 12-month period beginning on the date the standard is initially adopted, unless the Secretary determines that the modification is necessary in order to permit compliance with the standard.

"(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

"(i) IN GENERAL.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets.

"(ii) ADDITIONAL RULES.—If a code set is modified under this subsection, the modified code set shall include instructions on how data elements of health information that were encoded prior to the modification may be converted or translated so as to preserve the informational

value of the data elements that existed before the modification. Any modification to a code set under this subsection shall be implemented in a manner that minimizes the disruption and cost of complying with such modification.

"SEC. 1175. REQUIREMENTS.

"(a) CONDUCT OF TRANSACTIONS BY PLANS.—

"(1) IN GENERAL.—If a person desires to conduct a transaction referred to in section 1173(a)(1) with a health plan as a standard transaction—

"(A) the health plan may not refuse to conduct such transaction as a standard transaction;

"(B) the health plan may not delay such transaction, or otherwise adversely affect, or attempt to adversely affect, the person or the transaction on the ground that the transaction is a standard transaction; and

"(C) the information transmitted and received in connection with the transaction shall be in the form of standard data elements of health information.

"(2) SATISFACTION OF REQUIREMENTS.—A health plan may satisfy the requirements under paragraph (1) by—

"(A) directly transmitting and receiving standard data elements of health information; or

"(B) submitting nonstandard data elements to a clearinghouse for processing into standard data elements and transmission by the clearinghouse, and receiving standard data elements through the clearinghouse.

"(3) TIMETABLE FOR COMPLIANCE.—Paragraph (1) shall not be construed to require a health plan to comply with any standard, implementation specification, or modification to a standard or specification adopted or established by the Secretary under sections 1172 through 1174 at any time prior to the date on which the plan is required to comply with the standard or specification under subsection (b).

"(b) COMPLIANCE WITH STANDARDS.—

"(1) INITIAL COMPLIANCE.—

"(A) IN GENERAL.—Not later than 24 months after the date on which an initial standard or implementation specification is adopted or established under sections 1172 and 1173, each person to whom the standard or implementation specification applies shall comply with the standard or specification.

"(B) SPECIAL RULE FOR SMALL HEALTH PLANS.—In the case of a small health plan, paragraph (1) shall be applied by substituting '36 months' for '24 months'. For purposes of this subsection, the Secretary shall determine the plans that qualify as small health plans.

"(2) COMPLIANCE WITH MODIFIED STANDARDS.—If the Secretary adopts a modification to a standard or implementation specification under this part, each person to whom the standard or implementation specification applies shall comply with the modified standard or implementation specification at such time as the Secretary determines appropriate, taking into account the time needed to comply due to the nature and extent of the modification. The time determined appropriate under the preceding sentence may not be earlier than the last day of the 180-day period beginning on the date such modification is adopted. The Secretary may extend the time for compliance for small health plans, if the Secretary determines that such extension is appropriate.

"SEC. 1176. GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS AND STANDARDS.

"(a) GENERAL PENALTY.—

"(1) IN GENERAL.—Except as provided in subsection (b), the Secretary shall impose on any person who violates a provision of this part a penalty of not more than $100 for each such violation, except that the total amount imposed on the person for all violations of an identical requirement or prohibition during a calendar year may not exceed $25,000.

"(2) PROCEDURES.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil money penalty under this subsection in the same manner as such provisions apply to the imposition of a penalty under such section 1128A.

"(b) LIMITATIONS.—

"(1) OFFENSES OTHERWISE PUNISHABLE.—A penalty may not be imposed under subsection (a) with respect to an act if the act constitutes an offense punishable under section 1177.

"(2) NONCOMPLIANCE NOT DISCOVERED.—A penalty may not be imposed under subsection (a) with respect to a provision of this part if it is established to the satisfaction of the Secretary that the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person violated the provision.

"(3) FAILURES DUE TO REASONABLE CAUSE.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), a penalty may not be imposed under subsection (a) if—

"(i) the failure to comply was due to reasonable cause and not to willful neglect; and

"(ii) the failure to comply is corrected during the 30-day period beginning on the first date the person liable for the penalty knew, or by exercising reasonable diligence would have known, that the failure to comply occurred.

"(B) EXTENSION OF PERIOD.—

"(i) NO PENALTY.—The period referred to in subparagraph (A)(ii) may be extended as determined appropriate by the Secretary based on the nature and extent of the failure to comply.

"(ii) ASSISTANCE.—If the Secretary determines that a person failed to comply because the person was unable to comply, the Secretary may provide technical assistance to the person during the period described in subparagraph (A)(ii). Such assistance shall be provided in any manner determined appropriate by the Secretary.

"(4) REDUCTION.—In the case of a failure to comply which is due to reasonable cause and not to willful neglect, any penalty under subsection (a) that is not entirely waived under paragraph (3) may be waived to the extent that the payment of such penalty would be excessive relative to the compliance failure involved.

"SEC. 1177. WRONGFUL DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

"(a) OFFENSE.—A person who knowingly and in violation of this part—

"(1) uses or causes to be used a unique health identifier;

"(2) obtains individually identifiable health information relating to an individual; or

"(3) discloses individually identifiable health information to another person, shall be punished as provided in subsection (b).

"(b) PENALTIES.—A person described in subsection (a) shall—

"(1) be fined not more than $50,000, imprisoned not more than 1 year, or both;

"(2) if the offense is committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both; and

"(3) if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, fined not more than $250,000, imprisoned not more than 10 years, or both.

"SEC. 1178. EFFECT ON STATE LAW.

"(a) GENERAL EFFECT.—

"(1) GENERAL RULE.—Except as provided in paragraph (2), a provision or requirement under this part, or a standard or implementation specification adopted or established under sections 1172 through 1174, shall supersede any contrary provision of State law, including a provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form.

"(2) EXCEPTIONS.—A provision or requirement under this part, or a standard or implementation specification adopted or established under sections 1172 through 1174, shall not supersede a contrary provision of State law, if the provision of State law—

"(A) imposes requirements, standards, or implementation specifications that are more stringent than the requirements, standards, or implementation specifications under this part with respect to the privacy of individually identifiable health information; or

"(B) is a provision the Secretary determines—

"(i) is necessary to prevent fraud and abuse, or for other purposes; or

"(ii) addresses controlled substances.

"(b) PUBLIC HEALTH REPORTING.—Nothing in this part shall be construed to invalidate or limit the authority, power, or procedures established under any law provid-

ing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.

"SEC. 1179. HEALTH INFORMATION ADVISORY COMMITTEE.

"(a) ESTABLISHMENT.—There is established a committee to be known as the Health Information Advisory Committee (in this section referred to as the 'committee').

"(b) DUTIES.—The committee shall—

"(1) provide assistance to the Secretary in complying with the requirements imposed on the Secretary under this part;

"(2) study the issues related to the adoption of uniform data standards for patient medical record information and the electronic exchange of such information;

"(3) report to the Secretary not later than 4 years after the date of the enactment of this part recommendations and legislative proposals for such standards and electronic exchange; and

"(4) generally be responsible for advising the Secretary and the Congress on the status of the implementation of this part.

"(c) MEMBERSHIP.—

"(1) IN GENERAL.—The committee shall consist of 15 members of whom—

"(A) 3 shall be appointed by the President;

"(B) 6 shall be appointed by the Speaker of the House of Representatives after consultation with the minority leader of the House of Representatives; and

"(C) 6 shall be appointed by the President pro tempore of the Senate after consultation with the minority leader of the Senate.

The appointments of the members shall be made not later than 60 days after the date of the enactment of this part. The President shall designate 1 member as the Chair.

"(2) EXPERTISE.—The membership of the committee shall consist of individuals who are of recognized standing and distinction in the areas of information systems, information networking and integration, consumer health, health care financial management, or privacy, and who possess the demonstrated capacity to discharge the duties imposed on the committee.

"(3) TERMS.—Each member of the committee shall be appointed for a term of 5 years, except that the members first appointed shall serve staggered terms such that the terms of not more than 3 members expire at one time.

"(4) INITIAL MEETING.—Not later than 30 days after the date on which a majority of the members have been appointed, the committee shall hold its first meeting.

"(d) REPORTS.—Not later than 1 year after the date of the enactment of this part, and annually thereafter, the committee shall submit to the Congress, and make public, a report regarding—

"(1) the extent to which persons required to comply with this part are cooperating in implementing the standards adopted under this part;

"(2) the extent to which such entities are meeting the privacy and security standards adopted under this part and the types of penalties assessed for noncompliance with such standards;

"(3) whether the Federal and State Governments are receiving information of sufficient quality to meet their responsibilities under this part;

"(4) any problems that exist with respect to implementation of this part; and

"(5) the extent to which timetables under this part are being met.".

(b) CONFORMING AMENDMENTS.—

(1) REQUIREMENT FOR MEDICARE PROVIDERS.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(A) by striking "and" at the end of subparagraph (P);

(B) by striking the period at the end of subparagraph (Q) and inserting "; and"; and

(C) by inserting immediately after subparagraph (Q) the following new subparagraph:

"(R) to contract only with a clearinghouse (as defined in section 1171) that meets each standard and implementation specification adopted or established under part C of title XI on or after the date on which the clearinghouse is required to comply with the standard or specification.".

(2) TITLE HEADING.—Title XI (42 U.S.C. 1301 et seq.) is amended by striking the title heading and inserting the following:

"TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION".

PURPOSE AND SUMMARY

A significant problem in the health insurance market is the difficulty small businesses and individuals experience in obtaining adequate health insurance coverage. The purpose of H.R. 3070, the Health Coverage Availability and Affordability Act of 1996, is to make health insurance more accessible by reducing the barriers which (1) make it difficult for small employers to obtain adequate health insurance coverage for their employees, and (2) impede access to insurance coverage for individuals who change or lose their jobs.

The bill also addresses the affordability of health insurance coverage by including provisions to strengthen protection against health care fraud and abuse, and provisions which will provide for administrative simplification in filing claims. The General Accounting Office has estimated that fraud and abuse account for one out of every ten dollars spent on health care. Providing for concrete laws and guidelines and stringent penalties for violations will ensure the continued integrity of the health care system. The administrative simplification provisions will ensure that there are standards for the transmission of financial and administrative data. Much of this information is currently transmitted in an electronic format. However, there is not a uniform standard and there are not consistent security standards or safeguards regarding the use of this information.

At the core of this bill is the Committee's recognition of the problem of "job lock", that is an employee's reluctance to change jobs because of the application of new or nonuniform preexisting condition exclusions. This problem affects employment on an interstate basis, as well as the productivity of businesses acting in interstate commerce. In addition, the delivery of health care services in connection with group and individual health plans is increasingly interstate in nature, as health care is provided to patients through interstate commerce. The Committee finds that it is necessary for the Federal government to address the issue of group-to- individual health insurance coverage portability, as well as group-to-group health insurance coverage portability, in order to address this issue. However, the Committee recognizes the traditional role of States in regulating health care insurance, and has accommodated that need by deferring to States that have adopted laws consistent with the requirements of this Act and the Employee Retirement Income Security Act of 1974 (ERISA).

Title I, Improved Availability and Portability of Health Insurance Coverage, addresses a number of interrelated issues in the group health plan and individual insurance market. These include: limitations on preexisting condition exclusions; portability of prior satisfaction of preexisting condition exclusions; guaranteed renewability; prohibition on excluding individuals from coverage because of health status; guaranteed availability of insurance coverage in the small group market; and guaranteed issue of individual policies for certain previously insured individuals.

Title I addresses these issues with respect to employer group health plans, insurers, and health maintenance organizations (HMOs). The bill ensures the portability of health insurance for individuals moving from one group health plan to another by prohibiting group health plans, insurers, and health maintenance organizations from imposing a preexisting condition exclusion that exceeds 12 months for conditions for which medical advice, diagnosis, or treatment was received or recommended within the previous 6 months. Preexisting conditions could not be applied to newborns, adopted children, or pregnancy. A preexisting condition limitation period would be reduced by the length of the aggregate period of any qualified prior coverage. The bill assures that, once covered, the condition will not be excluded from future coverage if the individual meets the requirements of the bill. These provisions assure that individuals who have an opportunity to move to new jobs will not have to face limitations in their coverage for preexisting medical conditions that affect them or their families.

Title I also addresses the small group market. It provides for guaranteed availability of coverage to employees in the small group market. Each insurer that offers coverage in the small group market would have to accept every small employer and accept for enrollment every eligible individual within the same employer. The bill also assures people in group health plans that they cannot be excluded from coverage or from renewing their coverage based on their health status.

H.R. 3070 would also ensure portability of health insurance for qualifying individuals moving from group to individual coverage. The goals of these provisions are to guarantee that qualifying individuals are able to obtain health insurance and to receive credit for their prior coverage toward the new coverage's preexisting condition exclusion period. This is accomplished by giving States flexibility to achieve the guarantee of group to individual coverage through a variety of means that may include risk pools, group conversion policies, open enrollment by one or more insurers, guaranteed issue, or any combination thereof. If a State does not elect to implement its own availability mechanism, or if the Secretary has found that a State's mechanism was not reasonably designed to meet the availability goals of the Act, Federal guaranteed availability requirements would apply. An insurer or HMO in a State issuing individual health insurance coverage would have to offer one qualifying insurance policy to each qualifying individual in the State and could not decline to issue such coverage based on health status. The qualifying coverage would have to be a plan equal to the average actuarial value of the plans offered in the individual market by the insurer or HMO; or equal to the average actuarial value of all plans offered by all insurers and HMOs in the individual market in the State and in which there either is no preexisting condition limitation or such limit is no greater than that in group health plans.

Title II, Preventing Health Care Fraud and Abuse; Administrative Simplification, addresses issues relating to health care fraud and abuse and administrative simplification.

Title II creates a Health Care Fraud and Abuse Account within the Federal Hospital Insurance Fund. Monies derived from the

newly coordinated health care anti-fraud and abuse programs, civil monetary penalties, fines, and forfeitures assessed in criminal and civil cases would be transferred into the Trust Fund. Mandatory appropriations are also established for the FBI, Inspector General, and the Medicare Integrity Program to modernize and strengthen Medicare's fraud and abuse activities. The other provisions of Title II related to health care fraud and abuse: require the Secretary of Health and Human Services and the Attorney General to jointly establish a national health care fraud and abuse control program to coordinate Federal, State and local law enforcement to combat fraud with respect to health plans; establish a Medicare Integrity Program; require the Secretary to provide beneficiaries with an explanation of each item or service for which payment was made under Medicare; require the Secretary to establish a program to encourage individuals to report suspected fraud and abuse in the Medicare program; extend certain criminal penalties for fraud and abuse violations under the Medicare and Medicaid programs to similar violations in Federal health care programs generally; require the Secretary to issue written advisory opinions with respect to activities subject to fraud and abuse sanctions; require the Inspector General to issue fraud alerts; require the Secretary to exclude from Medicare and State health care programs for a minimum of 5 years individuals and entities who have been convicted of felony offenses relating to health care fraud or controlled substances; provide an additional exception to the anti-kickback provisions for discounting and managed care arrangements; establish a criminal penalty for the fraudulent disposition of assets in order to obtain Medicaid benefits; apply the provisions under the Medicare and Medicaid programs which provide for civil money penalties for specified fraud and abuse violations to similar violations involving other Federal health care programs; clarify the level of intent required for imposition of civil monetary penalties; establish an additional civil money penalty for false certification for home health services; and revise criminal law with respect to health care fraud, theft or embezzlement, false statements, obstruction of criminal investigations of health care offenses, and money laundering related to health care fraud.

The main provisions of Title II related to administrative simplification would improve the Medicare and Medicaid programs and the efficiency of the health care system by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health care information.

Background and Need for Legislation

Among the 262 million people in the United States in 1994, an estimated 222 million (84.8 percent) were covered by some form of health insurance coverage. The remaining 15.2 percent (39.7 million people) of the population were uninsured. This is an increase from about 14 percent of the nonelderly population in 1987. In 1994, the rate of employment-based health insurance coverage increased as firm size increased. Among workers and dependents of workers in large firms (1,000 or more employees), 92 percent were

insured, compared to 67 percent in small firms of under 10 employees.

One reason for the increasing rate of uninsured is that health insurance has become less available and affordable, especially in the small group and individual markets. Part of this trend is attributable to the underlying costs of coverage. However, part of this trend is also attributable to certain underwriting practices used by insurers and employers to restrict the availability of insurance for people with preexisting medical conditions or other characteristics associated with above-average utilization of health care. As a result, small businesses and individuals may be less and less able to find affordable coverage. The prevalence of such practices is also thought to contribute to "job lock" in which workers pass up the opportunity to move to a new and perhaps better job because they fear they will not be able to get insurance from the new employer, or that coverage under the new employer's health plan will be limited as a result of preexisting condition clauses.

While all of these practices have created difficulties in the small group market, they are more pronounced in the individual market. Compared with group insurance, the individual health insurance market is very small. For about 58 percent of those with individual insurance, such coverage was their only source of insurance; the rest had individual insurance in addition to some other type of coverage (typically Medigap coverage to supplement Medicare).

Those with individual coverage may have "converted" to such coverage from a group policy. Approximately 38 State insurance laws require policies sold in the State to include the option of converting to an individual policy sold by the same insurer, without showing evidence of medical insurability when coverage under the group contract terminates. However, the individual policy's benefits are often less generous than those of the group plan and the premium is usually larger.

One of the major differences between individual and group insurance coverage is that the individual market has a significantly higher level of underwriting risk which leads to greater medical underwriting. Underwriting for individual insurance is considered more risky because individuals are not part of a group across which risk can be spread. Also, many applicants in the individual market wait to buy coverage until they become ill and need medical care. Consequently, some applicants may have to undergo specific medical tests or a complete physical, and may be refused coverage on the basis of these results. Also, an individual applicant who is not in the workforce (and thus not covered under an employer plan) tends to be more likely to have existing medical problems. After examination of such factors as health status, medical history, occupation, and habits of an individual applicant, the insurer or HMO may (1) reject the individual because of an existing health condition, or (2) cover the individual but require a waiting period or exclude coverage for the preexisting condition.

Under large group coverage, the health status and medical history of each member are typically not examined. When a group is of sufficient size, actuarial principles guarantee that the claims experience of the group will balance out above and below average individual medical risks. Therefore, there is no need for medical un-

derwriting. Other factors, such as financial status and industry classification, would be evaluated for large groups. Small groups, however, are usually subject to the medical underwriting process, with the insurer examining the risk associated with each member of the group.

Underwriting in the individual market varies by insurer, subject to any State restrictions. However, such plans often provide fewer benefits, require higher-than-average premiums, or impose higher enrollee cost-sharing requirements. Waiting periods may be required before benefits are paid for preexisting conditions, or preexisting conditions may be excluded altogether.

Specifically, such practices in both the small group market and the individual market include:

Denial of Coverage. Insurers may deny coverage to entire firms that are in industries thought to involve high medical risks (e.g., construction), seasonal or high-turnover employment (e.g., parking garages), or a high risk of failure and nonpayment (e.g., restaurants). In underwriting very small firms, an insurer may consider the medical history or health status of each employee. Underwriting is the process through which an insurer evaluates the risk presented by an individual or group seeking insurance, and then either refuses to insure such risk or determines the conditions under which the risk will be accepted. A firm with one high-cost employee may be refused coverage, or the firm may be offered coverage only if that employee is excluded.

Preexisting condition exclusions. A group or individual may be offered coverage that excludes payment, temporarily or permanently, for a disease or condition that exists at the time the coverage takes effect. For example, a policy may provide that there will be no payment during the first year of coverage for any condition that was diagnosed or treated within six months to two years before the coverage took effect. The insurance will still pay for any new, unrelated medical problem. A patient suffering from heart disease might not be paid for treatment for that condition, but might be paid for treatment of a broken arm. While preexisting exclusions are not the same as outright denial of coverage, they might well have the same practical effect for purchasers with existing health problems.

Non-renewal. An insurer may issue a policy for a fixed period and may refuse to renew coverage for a group or individual that has incurred or is expected to incur high costs. Most States now place some restrictions on the ability of insurers to cancel small group and/or individual coverage.

Health Care Costs: Fraud and Abuse, and Administrative Simplification. Issues related to fraud and abuse have also contributed to the high cost of health insurance coverage. According to the General Accounting Office (GAO), each year as much as 10 percent of total health care costs are lost to fraud and abuse. Given that annual health care costs in the United States are now approaching $1 trillion, fraud and abuse are costing taxpayers and policyholders large sums of money. Despite the enormity of the problem, GAO has concluded that only a small fraction of this fraud and abuse is detected.

Finally, issues related to simplifying health insurance data are important in improving the health insurance marketplace. The electronic transmission of health care claims is already occurring in the private sector. It is estimated that approximately 15 percent of the 4.8 billion annual health claims are currently submitted electronically. However, these transactions are not done in a standard format, thus creating more expense and burdens for health plans and providers. Providing standards for the electronic transmission of financial and administrative data presents an opportunity for significant administrative cost savings and enhanced fraud and abuse detection. Because this activity is already underway in the private sector it is imperative that standards be developed through a public-private partnership.

HEARINGS

The Subcommittee on Health and Environment held a hearing on Health Care Reform: Reforming the Small Business Marketplace and the Individual Health Insurance Market on March 7, 1996. Testimony was received from 14 witnesses, including representatives of the business industry, representatives of the health insurance industry, actuarial experts, and representatives of health consumer groups.

Testifying before the Subcommittee were: Ms. Ann Blakely, President, Earth Resources Corporation, on behalf of National Federation of Independent Business; Mr. Richard I. Smith, Vice President of Health Care Policy, Association of Private Pension Welfare Plans; Mr. Paul Huard, Senior Vice President of Policy and Communications, National Association of Manufacturers; Mr. Willis Gradison, President, Health Insurance Association of America; Mr. Mark Weinberg, Executive Vice President, National Business and Specialty Products, on behalf of The Blue Cross of California Wellpoint Health Network; Mr. Peter Ferrara, General Counsel and Chief Economist, Americans For Tax Reform; Mr. Merle Pederson, Counsel for Government Relations, Principal Financial Group; Ms. Pamela G. Bailey, President, Health Care Leadership Council; Ms. Judith Waxman, Director of Government Affairs, Families USA; Ms. Susan Rogan, Health Care Consumer; Mr. Tom Wildsmith, FSA, Health Insurance Association of America; Mr. Tom Stoiber, FSA/MAAA, American Academy of Actuaries; Ms. Beth Fuchs, Specialist in Social Legislation, Congressional Research Service; Mr. Brian Atchinson, Superintendent of Insurance for the State of Maine.

COMMITTEE CONSIDERATION

On March 14, 1996, the Subcommittee on Health and the Environment met in open markup session and approved H.R. 3070 for Full Committee consideration, without amendment, by a voice vote. On March 20, 1996, the Full Committee met in open markup session, and ordered H.R. 3070 reported to the House, as amended, by a rollcall vote of 38 yeas to 0 nays.

ROLLCALL VOTES

Clause 2(l)2(B) of rule XI of the Rules of the House requires the Committee to list the recorded votes on the motion to report legislation and amendments thereto. The following are the recorded votes on the motion to report H.R. 3070 and on amendments offered to the measure, including the names of those Members voting for and against.

COMMITTEE ON COMMERCE—104TH CONGRESS ROLLCALL VOTE NO. 125

Bill: H.R./ 3070, Health Coverage Availability and Affordability Act of 1996.

Amendment: Amendment by Ms. Furse re: preemption.

Representative	Yeas	Nays
Mr. Bliley		X
Mr. Moorhead		
Mr. Tauzin		X
Mr. Fields		X
Mr. Oxley		X
Mr. Bilirakis		X
Mr. Schaefer		X
Mr. Barton		
Mr. Hastert		X
Mr. Upton		X
Mr. Stearns		X
Mr. Paxon		X
Mr. Gillmor		
Mr. Klug		
Mr. Franks		X
Mr. Greenwood		X
Mr. Crapo		X
Mr. Cox		
Mr. Deal		X
Mr. Burr		X
Mr. Bilbray		X
Mr. Whitfield		X
Mr. Granske		X
Mr. Frisa		X
Mr. Norwood		X
Mr. White		X
Mr. Coburn		X
Mr. Dingell	X	
Mr. Waxman	X	
Mr. Markey	X	
Mrs. Collins		
Mr. Hall		
Mr. Richardson	X	
Mr. Bryant		
Mr. Boucher	X	
Mr. Manton	X	
Mr. Towns	X	
Mr. Studds		
Mr. Pallone	X	
Mr. Brown	X	
Mrs. Lincoln	X	
Mr. Gordon	X	
Ms. Furse	X	
Mr. Deutsch	X	
Mr. Rush		
Ms. Eshoo	X	
Mr. Klink	X	
Mr. Stupak	X	

Representative	Yeas	Nays
Total	16	22

COMMITTEE ON COMMERCE—104TH CONGRESS ROLLCALL VOTE NO. 126

Bill: H.R. 3070, Health Coverage Availability and Affordability Act of 1996.

Amendment: Amendment by Mr. Stupak re: continuation of family coverage in cases of divorce or death of covered employee.

Representative	Yeas	Nays
Mr. Bliley		X
Mr. Moorhead		
Mr. Tauzin		X
Mr. Fields		
Mr. Oxley		X
Mr. Bilirakis		X
Mr. Schaefer		X
Mr. Barton		
Mr. Hastert		X
Mr. Upton		X
Mr. Stearns		
Mr. Paxon		X
Mr. Gillmor		X
Mr. Klug		
Mr. Franks		X
Mr. Greenwood		X
Mr. Crapo		X
Mr. Cox		
Mr. Deal		X
Mr. Burr		X
Mr. Bilbray		X
Mr. Whitfield		X
Mr. Ganske		X
Mr. Frisa		X
Mr. Norwood		X
Mr. White		X
Mr. Coburn		X
Mr. Dingell	X	
Mr. Waxman	X	
Mr. Markey	X	
Mrs. Collins		
Mr. Hall		
Mr. Richardson	X	
Mr. Bryant		
Mr. Boucher	X	
Mr. Manton	X	
Mr. Towns	X	
Mr. Studds		
Mr. Pallone	X	
Mr. Brown	X	
Mrs. Lincoln		X
Mr. Gordon	X	
Mr. Furse	X	
Mr. Deutsch	X	
Mr. Rush		
Ms. Eshoo	X	
Mr. Klink	X	
Mr. Stupak	X	
Total	14	23

COMMITTEE ON COMMERCE—104TH CONGRESS ROLLCALL VOTE NO. 127

Bill: H.R. 3070, Health Coverage Availability and Affordability Act of 1996.

Amendment: Amendment by Mr. Deutsch re: coverage of injured public safety officers.

Representative	Yeas	Nays
Mr. Bliley		X
Mr. Moorhead		
Mr. Tauzin		X
Mr. Fields		
Mr. Oxley		X
Mr. Bilirakis		X
Mr. Schaefer		X
Mr. Barton		
Mr. Hastert		X
Mr. Upton		X
Mr. Stearns		
Mr. Paxon		X
Mr. Gillmor		X
Mr. Klug		
Mr. Franks		X
Mr. Greenwood		X
Mr. Crapo		X
Mr. Cox		
Mr. Deal		X
Mr. Burr		X
Mr. Bilbray		
Mr. Whitfield		X
Mr. Ganske		X
Mr. Frisa		X
Mr. Norwood		X
Mr. White		X
Mr. Coburn	X	
Mr. Dingell	X	
Mr. Waxman	X	
Mr. Markey		
Mrs. Collins		
Mr. Hall	X	
Mr. Richardson	X	
Mr. Bryant		
Mr. Boucher	X	
Mr. Manton	X	
Mr. Towns	X	
Mr. Studds		
Mr. Pallone	X	
Mr. Brown	X	
Mrs. Lincoln	X	
Mr. Gordon	X	
Ms. Furse	X	
Mr. Deutsch	X	
Mr. Rush		
Mr. Eshoo	X	
Mr. Klink	X	
Mr. Stupak	X	
Total	17	19

COMMITTEE ON COMMERCE—104TH CONGRESS ROLLCALL VOTE NO. 128

Bill: H.R. 3070, Health Coverage Availability and Affordability Act of 1996.

Amendment: Amendment by Mr. Hastert to the Amendment offered by Mr. Dingell and Mr. Pallone re: strike the text and insert

in lieu thereof a new Subtitle C—Sense of the Committee on Additional Requirements.

Representative	Yeas	Nays
Mr. Bliley	X	
Mr. Moorhead	X	
Mr. Tauzin	X	
Mr. Fields	X	
Mr. Oxley	X	
Mr. Bilirakis	X	
Mr. Schaefer	X	
Mr. Barton	X	
Mr. Hastert	X	
Mr. Upton	X	
Mr. Stearns	X	
Mr. Paxon	X	
Mr. Gillmor	X	
Mr. Klug	X	
Mr. Franks	X	
Mr. Greenwood	X	
Mr. Crapo	X	
Mr. Cox	X	
Mr. Deal	X	
Mr. Burr	X	
Mr. Bilbray		
Mr. Whitfield	X	
Mr. Ganske	X	
Mr. Frisa		
Mr. Norwood	X	
Mr. White	X	
Mr. Coburn		
Mr. Dingell		X
Mr. Waxman		X
Mr. Markey		X
Mrs. Collins		
Mr. Hall		X
Mr. Richardson		X
Mr. Bryant		
Mr. Boucher		X
Mr. Manton		X
Mr. Towns		
Mr. Studds		
Mr. Pallone		X
Mr. Brown		X
Mrs. Lincoln		X
Mr. Gordon		X
Ms. Furse		X
Mr. Deutsch		X
Mr. Rush		
Ms. Eshoo		X
Mr. Klink		
Mr. Stupak		X
Total	24	15

COMMITTEE ON COMMERCE—104TH CONGRESS ROLLCALL VOTE NO. 129

Bill: H.R. 3070, Health Coverage Availability and Affordability Act of 1996.

Amendment: Amendment by Mr. Dingell re: strike the section relating to clarification of level of intent required for imposition of sanctions.

Representative	Yeas	Nays
Mr. Bliley		X

Representative	Yeas	Nays
Mr. Moorhead	.....	X
Mr. Tauzin	.....	X
Mr. Fields	.....	X
Mr. Oxley	.....	X
Mr. Bilirakis	.....	X
Mr. Schaefer	.....	X
Mr. Barton	.....	.....
Mr. Hastert	.....	X
Mr. Upton	.....	X
Mr. Stearns	.....	X
Mr. Paxon	.....	X
Mr. Gillmor	.....	X
Mr. Klug	.....	X
Mr. Franks	.....	X
Mr. Greenwood	.....	X
Mr. Crapo	.....	X
Mr. Cox	.....	X
Mr. Deal	.....	X
Mr. Burr	.....	X
Mr. Bilbray	.....	.....
Mr. Whitfield	.....	.....
Mr. Ganske	.....	.....
Mr. Frisa	.....	.....
Mr. Norwood	.....	X
Mr. White	.....	X
Mr. Coburn	.....	X
Mr. Dingell	X	.....
Mr. Waxman	X	.....
Mr. Markey	.....	.....
Mrs. Collins	.....	.....
Mr. Hall	.....	.....
Mr. Richardson	X	.....
Mr. Bryant	.....	.....
Mr. Boucher	X	.....
Mr. Manton	X	.....
Mr. Towns	.....	.....
Mr. Studds	.....	.....
Mr. Pallone	X	.....
Mr. Brown	X	.....
Mrs. Lincoln	X	.....
Mr. Gordon	X	.....
Ms. Furse	X	.....
Mr. Deutsch	X	.....
Mr. Rush	.....	.....
Ms. Eshoo	X	.....
Mr. Klink	X	.....
Mr. Stupak	X	.....
Total	14	22

COMMITTEE ON COMMERCE—104TH CONGRESS ROLLCALL VOTE NO. 130

Bill: H.R. 3070, Health Coverage Availability and Affordability Act of 1996.

Amendment: Motion by Mr. Bliley to order H.R. 3070, as amended, reported to the House.

Representative	Yeas	Nays
Mr. Bliley	X	.....
Mr. Moorhead	X	.....
Mr. Tauzin	X	.....
Mr. Fields	X	.....
Mr. Oxley	X	.....
Mr. Bilirakis	X	.....

Representative	Yeas	Nays
Mr. Schaefer	X	
Mr. Barton		
Mr. Hastert	X	
Mr. Upton	X	
Mr. Stearns	X	
Mr. Paxon	X	
Mr. Gillmor	X	
Mr. Klug	X	
Mr. Franks	X	
Mr. Greenwood	X	
Mr. Crapo	X	
Mr. Cox		
Mr. Deal	X	
Mr. Burr	X	
Mr. Bilbray		
Mr. Whitfield	X	
Mr. Ganske	X	
Mr. Frisa		
Mr. Norwood	X	
Mr. White	X	
Mr. Coburn	X	
Mr. Dingell	X	
Mr. Waxman	X	
Mr. Markey	X	
Mrs. Collins		
Mr. Hall		
Mr. Richardson	X	
Mr. Bryant		
Mr. Boucher	X	
Mr. Manton	X	
Mr. Towns		
Mr. Studds		
Mr. Pallone	X	
Mr. Brown	X	
Mrs. Lincoln	X	
Mr. Gordon	X	
Ms. Furse	X	
Mr. Deutsch	X	
Mr. Rush		
Ms. Eshoo	X	
Mr. Klink	X	
Mr. Stupak	X	
Total	38	0

COMMITTEE ON COMMERCE—104TH CONGRESS MARCH 20, 1996

Bill: H.R. 3070, Health Coverage Availability and Affordability Act of 1996.

AMENDMENTS PASSED BY VOICE VOTES

Amendment: En Bloc Amendment by Mr. Bilirakis re: technical and clarifying amendments.

Disposition: Agreed to, by a voice vote.

Amendment: Amendment by Mr. Waxman re: pre-existing condition limitation for certain individuals in the individual market.

Disposition: Agreed to, by a voice vote.

Amendment: Amendment by Mr. Dingell and Mr. Pallone re: additional requirements.

Disposition: Agreed to, as amended, by a voice vote.

Amendment: Amendment by Mr. Waxman re: nondiscrimination in premium contributions.

Disposition: Withdrawn, by unanimous consent.

Amendment: Amendment in the Nature of a Substitute by Mr. Waxman.

Disposition: Not Agreed to, by a voice vote.

AMENDMENTS RULED NONGERMANE

Amendment: Amendment by Mr. Richardson re: nondiscriminatory limits for treatment of severe mental illness.

Disposition: Point of Order Against the Amendment on the grounds that it was nongermane was upheld.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(l)(3)(A) of rule XI of the Rules of the House of Representatives, the Committee held an oversight hearing and made findings that are reflected in this report.

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

Pursuant to clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Reform and Oversight.

NEW BUDGET AUTHORITY AND TAX EXPENDITURES

In compliance with clause 2(l)(3)(B) of rule XI of the Rules of the House of Representatives, the Committee states that H.R 3070 would result in no new or increased budget authority or tax expenditures or revenues.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 403 of the Congressional Budget Act of 1974.

In December of 1995, the Congressional Research Service (CRS) was asked by the Chairman of the Senate Labor and Human Resources Committee to provide an objective actuarial evaluation of the effects of S. 1028 group-to-individual portability provisions on the cost of the coverage for the currently individually-insured population. CRS contracted with Hay/Huggins, a nationally known actuarial firm, to conduct the analysis. The Hay actuaries estimated that if States limited the size of premiums charged to this new population entering the individual market to 200 percent of the average group premium, than individual premiums for the entire market would increase by less than 1 percent in the first year and by no more than 3 percent at the point where the maximum number of newly insured were brought into the market by the group-to-individual portability provisions of S. 1028.

The Chairman of the Committee on Commerce asked the Congressional Research Service to have Hay/Huggins perform a similar assessment of the group-to-individual portability provisions of H.R. 3070. The Hay/Huggins actuarial analysis is included in Appendix A. It concludes that if the same assumptions are made about pre-

miums, the language in H.R. 3070 would also increase premiums by 1 to 3 percent.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 2(l)(3)(C) of rule XI of the Rules of the House of Representatives, following is the cost estimate provided by the Congressional Budget Office pursuant to section 403 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, March 25, 1996.

Hon. THOMAS J. BLILEY, Jr.
Chairman, Committee on Commerce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office (CBO) has reviewed H.R. 3070, the Health Coverage Availability and Affordability Act of 1996, as ordered reported by the House Committee on Commerce on March 20, 1996. Enclosed are CBO's federal cost estimate and estimates of the costs of intergovernmental and private sector mandates.

If you wish further details on these estimates, we will be pleased to provide them. The CBO staff contacts are identified in the separate estimates.

Sincerely,

JUNE E. O'NEILL, *Director.*

Enclosures.

CONGRESSIONAL BUDGET OFFICE FEDERAL COST ESTIMATE

1. Bill number: H.R. 3070.
2. Bill title: Health Coverage Availability and Affordability Act of 1996.
3. Bill status: As ordered reported by the House Committee on Commerce on March 20, 1996.
4. Bill purpose: Title I would make it easier for people who change jobs to maintain health insurance coverage by limiting exclusions for preexisting conditions and increasing portability of coverage.

Title II would prevent health care fraud and abuse and would simplify the administration of health insurance.

5. Estimated cost to the Federal Government: H.R. 3070 could affect federal revenues, but the impact would be insignificant. CBO estimates that H.R. 3070 would reduce federal outlays by $2,540 million over seven years (see the attached table).
6. Basis of the estimate:

TITLE I, HEALTH INSURANCE PORTABILITY

H.R. 3070 would create uniform national standards intended to improve the portability of private health insurance policies. For example, these standards would allow workers with employment-based policies to continue their coverage more easily when changing or leaving jobs. Because most private insurance plans require a waiting period before new enrollees become eligible for coverage,

especially for those with preexisting medical conditions, workers with chronic conditions or other health risks may face gaps in their coverage when they change jobs. Alternatively, such workers may be hesitant to change jobs because they fear the temporary loss of coverage—a situation known as job-lock.

The bill would reduce the effective length of exclusions for preexisting conditions by crediting enrollees for continuous coverage by a previous insurer. Insurance companies would be prohibited from denying certain coverages based on the medical status or experience of individuals or groups and would be required to renew coverage in most cases. Insurers could not deny coverage to individuals who had exhausted their continuing coverage from a previous employer. This bill would allow individuals to change their enrollment status without being subject to penalties for late enrollment if their family or employment status changed during the year. To the extent that states have not already implemented similar rules, these changes would clarify the insurance situation and possibly reduce gaps in coverage for many people.

Because the bill would not regulate the premiums that plans could change, the number of people covered by health insurance and the premiums that they pay would continue to be influenced primarily by market forces. Although this provision would make insurance more portable for some people, it would not dramatically increase the availability of insurance in general.

Budgetary impact

CBO estimates that the insurance portability provisions of H.R. 3070 would not have a significant effect on federal revenues or outlays.

Impact on Federal revenues

According to the General Accounting Office (GAO), 38 states have enacted legislation to improve the portability and renewability of health plans among small employers. State laws do not apply to employees of firms with self-insurance plans, although large employer plans—those most likely to self-insure—generally have fewer exclusions for preexisting conditions than smaller firms. Health maintenance organizations and other health plans that use organized networks of health providers use few exclusions for preexisting conditions within their networks. Most group insurance is now provided through these managed care networks.

The new standards for the portability of group insurance created by H.R. 3070 would increase the price of health insurance for group plans, with a corresponding reduction in coverage. Because many insurance reforms have already been implemented by the states, however, and because most health plans do not use long exclusions for preexisting conditions, these changes would be small. The standards for group-to-individual portability of insurance could lower premiums for group insurance if people with preexisting conditions and consequently high health costs took advantage of the guarantee of individual coverage that H.R. 3070 would provide. These people, who currently stay on the job to retain coverage, would reduce spending for employer-sponsored insurance by switching from group to individual coverage.

On balance, CBO does not expect the total contributions for health insurance made by employers to change. As a result, federal revenues are unlikely to be significantly changed.

Impact on Federal outlays

CBO estimates that federal outlays for Medicaid would not change because any persons eligible for free coverage from Medicaid under current law would also seek out Medicaid coverage if H.R. 3070 was enacted. CBO also estimates that the bill would cause no appreciable changes to federal outlays for Medicare, Federal Employees Health Benefits, or other federal programs.

TITLE II, LIMITING FRAUD AND ABUSE AND ADMINISTRATIVE SIMPLIFICATION

Limiting fraud and abuse

The proposal includes several proposals to limit fraud and abuse in Medicare.

Payment safeguards and enforcement

The bill would establish mandatory appropriations for Medicare payment safeguards and for the anti-fraud activities of the Inspector General (IG) of the Department of Health and Human Services (HHS) and the Federal Bureau of Investigation (FBI). It would also increase the resources devoted to these two activities. After a few years, reduced Medicare spending and additional fines and penalties would more than offset the added administrative costs. Over the 1996–2002 period, the net savings would total $2,900 million.

CBO's estimate attributes savings only to the projected increase in resources, not to the base level itself. The estimate assumes that the Health Care Financing Administration (HCFA), the IG, and the FBI could productively use only limited additional resources each year, and that additional resources would be subject to diminishing marginal returns. Based on studies by the General Accounting Office and HCFA, the estimate assumes that an additional dollar devoted to HCFA payment safeguard activities would at first return eight dollars in lower benefit payments. Data from the IG indicate that an additional dollar devoted to its enforcement efforts would initially return seven dollars in recoveries. The estimate assumes that the marginal benefit-to-cost ratio in each case would decline to approximately four-to-one by 2002. Date on recoveries from the FBI's Health Care Fraud Unit indicate an initial nine-to-one ratio of recoveries to cost. As with HHS, the estimate assumes that the ratio at the margin would decay over time to less than seven-to-one by 2002.

Additional health care fraud and abuse guidance

The bill would require the Secretary to create a program enabling providers of health care to seek advisory opinions regarding the application of health care fraud and abuse sanctions. According to the IG, such a provision would substantially hinder its ability to prosecute fraud and abuse cases successfully. It would also require the IG to hire additional legal staff. Based on data provided by the IG, CBO estimates that this provision would cost $390 million in

lost recoveries and additional staff over the 1996–2002 period. If this proposal is adopted, CBO expects that the savings would be documented and subject to an independent audit. These documented savings would then be used to make an estimates of new proposals and provide a basis for updating projections of spending under current law.

New and increased civil monetary penalties

The bill would increase current law civil monetary penalties for fraudulent claims for reimbursement under Medicare and Medicaid and apply these penalties to all federal health care programs. New civil monetary penalties would apply to individuals who retained control of a provider entity while they were excluded from Medicare or a State health care program, coded billed procedures incorrectly, prescribed services that were not medically necessary, offered kickbacks for using particular providers, or falsely certified home health services, and to Medicare health maintenance organizations (HMOs) that failed to fulfill their contracts. Based on an analysis of the recoveries generated by the IG's current caseload and expectations of the impact of the new penalties, CBO estimates that these provisions would generate $320 million in savings over the 1996–2003 period.

Additional exclusion authorities

The bill would require the Secretary of HHS to exclude providers from program participation for three years following felony convictions for fraud, obstructing an investigation, and controlled substance violations. Providers would be excluded for one year following the provision of substandard or unnecessary services and for the term of a provider's loss of license for violations of state law. The Secretary could also exclude individuals in control of a sanctioned entity. CBO estimates that these provisions would result in $190 million in fraud avoided over six years. The estimate is based on the IG's data on program savings resulting from provider convictions and expectations for additional successful actions.

Criminal provisions

The bill would make certain offenses involving health care fraud federal crimes. The bill would also grant the Attorney General the authority to subpoena information relating to suspected health care fraud. Based on conversations with officials of the Department of Justice, CBO assumes that these provisions would modestly increase successful prosecutions and result in recovery of $70 million in fraudulent Medicare payments over the next seven years.

In addition, the bill would create an additional exception to antikickback penalties for discounting and managed care arrangements. Based on recoveries data and conversations with the IG, CBO estimates that this would result in $580 million lost in antikickback recoveries.

Other items

The bill would require the Secretary of HHS to establish a fraud and abuse data collection program to report the final settlements from adverse actions against health care providers, suppliers, or

practitioners. The bill would also require the Secretary to establish a hotline and provide incentives for beneficiaries to report suspected fraud and to provide suggestions to improve the Medicare program. Based on an examination of a similar program operated by the Department of Defense, CBO estimates that this program would produce a net benefit of $30 million from additional recoveries over six years.

Administrative simplification

This provision would require the Secretary to adopt uniform standards and data elements for the electronic transmission of health information and claims. The Secretary would adopt standards developed by standard-setting organizations or a modification of these standards, with goal of reducing administrative costs. A Health Information Advisory Committee would assist the Secretary with this task and would make recommendations regarding standards and electronic data exchange. The proposal would also require the Secretary to take measures to protect the privacy and security of electronically transmitted health information. CBO estimates that this provision would cost the federal government $60 million over seven years. Because this spending would require appropriations action, these costs are not included in the attached table.

These new standards would apply to health plans, claims clearinghouses, and providers transmitting health information electronically, and would supersede existing state laws and regulations. Large health plans, clearing houses and providers must conform to these standards within 24 months of their adoption, while small plans would have 36 months to comply. Penalties would be levied against those who violated the standards or improperly used or distributed individually identifiable health information. However, these penalties would be waived if violators demonstrated reasonable cause or diligence.

7. Pay-as-you-go considerations: The Balanced Budget and Emergency Deficit Control Act of 1985 sets up pay-as-you go procedures for legislation affecting direct spending or receipts through 1998. The bill would have the following pay-as-you-go impact:

[By fiscal year, in millions of dollars]

	1996	1997	1998
Change in outlays	0	330	−100
Change in revenues	(1)	(1)	(1)

[1] Nor applicable.

8. Previous CBO estimate: COB has prepared cost estimates for several health care reform bills—S. 1028 as reported by the Senate Committee on labor and Human Resources, H.R. 995 as reported by the House Committee on Economic and Educational Opportunities, H.R. 3070 as reported by the House Committee on Commerce, and H.R. 3103 as reported by the House Committee on Ways and Means. All four bills contain provisions restricting preexisting conditions and increasing portability of health insurance. In addition, H.R. 3070 and H.R. 3103 contain provisions designed to reduce fraud and abuse in Medicare and simplify the administration of health insurance.

9. Estimate prepared by: Jeff Lemieux (insurance reform), Anne Hunt (administrative simplification), Cynthia Dudzinski (fraud and abuse).

10. Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

ESTIMATED BUDGETARY EFFECTS OF H.R. 3070

[By fiscal year, in billions of dollars]

	1996	1997	1998	1999	2000	2001	2002	Total
DIRECT SPENDING								
Title I	0	0	0	0	0	0	0	0
Title II: Fraud and abuse								
A. Recoveries from Payment Safeguards and law Enforcement	0	330	−110	−490	−780	−890	−960	−2,900
B. Cost of additional Health Care Fraud and Abuse Guidance	0	60	60	60	70	70	70	390
C. New and Increased Civil Monetary Penalties	0	−30	−50	−50	−60	−60	−70	−320
d. Additional Exclusion Authorities	0	−10	−10	−40	−40	−50	−50	−190
E. Criminal Provisions	0	−10	10	40	90	190	190	510
F. Other Items	0	(1)	(1)	(1)	(1)	(1)	(1)	−30
Total, Fraud and Abuse	0	330	−100	−480	−730	−740	−810	−2,540
Administrative Simplification								
A. Administrative Simplification Standards [2]	0	0	0	0	0	0	0	0
Total, Administrative Simplification	0	0	0	0	0	0	0	0
Total, Title II	0	330	−100	−480	−730	−740	−810	−2,540
Total, Outlays	0	330	−100	−480	−730	−740	−810	−2,540

[1] Savings or cost of less than $10 million.
[2] Costs of about $10 million per year for this provision would be discretionary spending.
Note: Estimate based on CBO December 1995 baseline assumptions.

CONGRESSIONAL BUDGET OFFICE ESTIMATE OF COSTS OF INTERGOVERNMENTAL MANDATES

1. Bill number: H.R. 3070.

2. Bill title: Health Coverage Availability and Affordability Act of 1996.

3. Bill status: As ordered reported by the House Committee on Commerce on March 20, 1996.

4. Bill purpose: Title I would make it easier for people who change jobs to maintain adequate coverage by limiting preexisting condition exclusions and increasing portability of coverage. State and local governments could elect to be exempt from these requirements. In addition, the bill would make reforms in the small group and individual insurance markets.

Title II would require the Secretary of Health and Human Services and the Attorney General to establish a program to control health care fraud. The program would include a national data base of criminal actions, civil actions, and license revocations against health care providers, practitioners, and suppliers. State and local governments would be required to provide this information for the data base.

Title II would also require the Secretary of Health and Human Services to establish national standards for health care transactions, such as claims and eligibility, that re transmitted electronically. Health care plans would be required to have the capability of receiving and transmitting this information three and one-half years after enactment.

5. Intergovernmental mandates contained in bill: H.R. 3070 contains various mandates, two of which have budgetary implications. First, state and local agencies would be required to report criminal and civil actions and license revocations against health care providers, practitioners, and suppliers. Second, state and local governments, as providers of health insurance or health care, would have to transmit health care transactions under new national standards.

6. Estimated direct costs to State, local, and tribal governments:

(a) Is the $50 Million Threshold Exceeded? No.

(b) Total Direct Costs of Mandates: Not significant.

(c) Estimate of Necessary Budget Authority: None.

Reporting requirements

State and local agencies would be required to report criminal and civil actions and license revocations against health care providers, practitioners, and suppliers. Based on the information from the National Association of Attorneys General and the National Health Care Anti-Fraud Association, CBO expects that this requirement would not impose a significant administrative burden on state and local governments. Most health care fraud cases carried out by states deal with Medicaid. under current law, states are already required to report criminal and civil actions relating to Medicaid to the Department of Health and Human Services.

National standards

The bill would require state and local governments, as providers of health insurance to their employees, to have the capability to receive and transmit transactions electronically under the national standards. Such transactions include enrollment, eligibility, and claims. Because the Secretary of Health and Human Services would be required to adopt standards only if they reduce the administrative costs of providing and paying for health care, this mandate should save states and local governments money in the long run. Some state and local governments would face one-time costs as they purchase computer hardware and software and reconfigure their computer systems. Because many of these health plans already have the hardware to transmit information electronically and many more will acquire the hardware over the next three and one-half years under current law, however, additional costs would be negligible.

The national standards would also apply to state and local government agencies that provide health care, for example, through public hospitals or clinics, and that transmit any health information electronically. CBO estimates that the additional costs faced by these providers would be negligible.

8. Appropriation or other Federal financial assistance provided in bill to cover mandate costs: None.

9. Other impacts on State, local, and tribal governments:

National standards

The capability to transmit health care information electronically would also apply to the Medicaid program. States are already in the forefront in administering the Medicaid program electronically; the only costs—which should not be significant—would involve bringing the software and computer systems for the Medicaid programs into compliance with the new standards. Moreover, under Public Law 104–4 increases in requirements for large entitlement programs are not considered mandates if the states have the programmatic flexibility to reduce their financial responsibilities. States have the ability to reduce their coverage of optional services or benefits.

Preexisting condition and portability

H.R. 3070 also would require state and local governments, as providers of health coverage to their employees, to comply with the preexisting condition and portability requirements unless they specifically opt out in a form and manner determined by the Secretary of Health and Human Services. If state and local governments decide to comply with these requirements, they would face an increase in health care costs of less than $50 million, a 0.1 percent increase in such costs. CBO estimates that state and local governments spend about $40 billion annually on health insurance for their employees. CBO assumes that state and local governments would pass these costs on to their employees in the form of adjustments to pay or other benefits.

Enforcement

States would have the option of enforcing the requirements of H.R. 3070 on issuers of group and individual health insurance. If a state decides not to enforce the new requirements, the federal government would do so. States currently regulate the group and individual insurance markets, and CBO does not expect any state to give up this authority and responsibility. States would thus incur additional costs as they enforce the new requirements. In 1995, according to the National Association of Insurance Commissioners, states spent $650 million regulating all form of insurance (health and others). CBO expects that H.R. 2070 would increase these costs only marginally.

Other impacts

H.R. 3070 would also require state and local governments to pay a fee if they want to access information from the national data base of health care fraud; these costs would not be significant. Finally, to the extent that the private sector mandates result in an increase in health care premiums collected by insurance companies and health maintenance organizations, state premium taxes would increase.

10. Previous CBO estimate: CBO has prepared cost estimates of various other health care reform bills—S. 1028 as reported by the Senate Committee on Labor and Human Resources on October 12, 1995, H.R. 995 as ordered reported by the House Committee on Economic and Educational Opportunities on March 6, 1995, and H.R. 3103 as ordered reported by the House Ways and Means on

March 19, 1996. All three bills have preexisting condition and portability provisions similar to those in H.R. 3070, but only under S. 1028 do these provisions constitute a mandate on state and local governments. The House bill allow state and local governments to opt out of these requirements. All three bills differ with respect to other provisions, but H.R. 3070 and H.R. 3103 would impose similar data reporting and electronic transmission requirements on state and local governments.

11. Estimate prepared by: John Patterson.

12. Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

CONGRESSIONAL BUDGET OFFICE ESTIMATE OF COSTS OF PRIVATE SECTOR MANDATES

1. Bill number: H.R. 3070.

2. Bill title: The Health Coverage Availability and Affordability Act of 1996.

3. Bill Status: As ordered reported by the House Committee on Commerce on March 20, 1996.

4. Bill purpose: The purpose of H.R. 3070 is to improve portability of health insurance coverage, to simplify administration of health insurance, and to reduce waste, fraud, and abuse in health insurance and health care delivery.

5. Private sector mandates contained in the bill: H.R. 3070 contains several private sector mandates as defined in P.L. 104–4. Provisions in Title I would affect both the group and employer-sponsored health insurance market and the individual insurance market.

Mandates on group insurers and employee health benefit plans

Title I of the bill would require sellers of health insurance in the small group market to accept every small employer within a state who applies as long as the employer meets participation and contribution rules set by the insurer. Those rules would have to be uniformly applied to all employers and be consistent with state law. A network plan or HMO could limit availability to those firms or employees within the geographic area served by the plan. Group insurers could stop selling coverage only under certain conditions, such as ceasing to offer coverage to any additional group purchasers. Under those circumstances, they could resume offering coverage only after an 180-day cessation. Group insurers in either the small or large group markets would be required to renew coverage at the option of the group purchaser, except in certain circumstances including nonpayment of premiums, or fraud or misrepresentation on the part of the group purchaser.

Several provisions of the bill would apply both to sellers of group insurance and to employee health benefit plans that are "self-insured" by firms. The bill would limit the use of pre-existing condition exclusions—clauses that exempt the plan from paying for expenses related to a medical condition that already existed when an enrolled first joined the plan. Under the bill, twelve months would be the maximum allowable duration of a pre-existing condition exclusion (eighteen months for employees who did not join the plan at their first enrollment opportunity). Furthermore, month-for-

month credit against that exclusion would have to be given to enrollees for continuous coverage that they had prior to joining a new plan. A break in coverage of 60 days or less would not be counted against the prior continuous coverage requirement. (Insurers and health benefit plans would be required to disclose information that would facilitate the administration of those "portability" requirements.) In addition, pregnancy could not be excluded by a pre-existing condition clause, and children who were signed up with a plan within thirty days of birth could not have any existing conditions excluded from coverage. (A similar provision applies for adopted children.)

Health maintenance organizations would be allowed to use "eligibility" periods, in which new enrollees would not be eligible for benefits, as long as pre-existing condition exclusions were not part of the plan. Such periods would be limited to sixty days (ninety days for late enrollees).

A health plan could not exclude an employee or his or her beneficiary from the plan on the basis of health status. The bill would require that group health plans offer special enrollment periods, during which enrollment in at least one benefit option would be possible, for participants or family members for various changes in family or employment status that resulted in a loss of insurance coverage.

Mandate affecting the individual insurance market

Under Title I of the bill, sellers of individual health insurance policies would be required to offer coverage to individuals who wanted to enroll in an individual health plan, regardless of their health status, if they had at least 18 months of continuous coverage under a group, governmental, or church health plan. To be eligible for such group-to-individual market "portability," the individual applicant would have to be ineligible for group coverage or for COBRA continuation coverage. The actuarial value of the benefits offered to individuals under this provision could not be less than either: (a) the weighted average actuarial value of the benefits for all the individual insurance policies issued by the insurer or HMO in the state in the previous year; or (b) the weighted average actuarial value of the benefits for all individual insurance policies issued by all insurers and HMOs in the state in the previous year. (Either the plan or the state would decide which option to use.)

Issuers of individual plans also would be required to renew policies at the option of the insured individuals, except under certain circumstances including nonpayment of premiums or fraud.

To the extent that state laws or regulations were suitable substitutes for the provisions of the bill, the federal rules would not apply. Examples of such substitutes include health insurance pools or programs authorized or established by the state, mandatory group conversion policies, guaranteed issue of one or more individual insurance plans, or open enrollment by one or more insurers or HMOs. States wishing to establish public or private mechanisms to meet the federal standards would have until July 1, 1997 (or until July 1, 1998 if their legislatures did not meet in the first six months of 1997) to do so.

Other mandates

Title II of the bill would impose a mandate on all private sector insurers and those providers who submit claims electronically. It would require that certain specified health-related electronic transmittals conform to standards adopted by the Secretary of Health and Human Services. The bill states that any standards adopted must reduce the administrative costs of providing and paying for health care. Title II would also establish a health care fraud and abuse data collection program, with a mandate on each government agency and private health plan to report any final adverse action taken against a health care provider, supplier, or practitioner.

6. Estimated direct cost to the private sector: CBO estimates that the direct cost of the main private sector mandates in H.R. 3070 would be approximately $350 million in the first year the provisions were effective, rising to about $500 million annually in the fifth year. Those mandate costs represent about one-quarter of one percent of total private sector health insurance expenditures, although their distribution among health insurance plans would be uneven. (Plans that cover public sector employees are not included in this analysis.) These estimates are subject to considerable uncertainty because a number of underlying assumptions rely on limited data or judgments about future changes in health insurance markets.

The specific mandates examined in this estimate are:

Limiting the length of time employer-sponsored and group insurance plans could withhold coverage for pre-existing conditions.

Requiring that periods of continuous prior health plan coverage be credited against pre-existing condition exclusions of a new plan.

Requiring issuers of individual health insurance policies to offer coverage to all individuals who meet specific requirements, including 18 months of prior continuous group or employer-sponsored coverage.

CBO estimates that the direct cost of the mandates in Title II of the bill would be negligible. Health plans (and those providers who choose to submit claim electronically) would be required to modify their computer software to incorporate new standards as they are adopted or modified, but modifications could not be made more frequently than once every six months. Uniform standards would generate offsetting savings for plans and providers by simplifying the claims process and coordination of benefits. Data reporting requirements for the health care fraud and abuse data collection program would be negligible.

Basis of the estimate: The remainder of the analysis discusses the basis for CBO's estimate of the direct cost of the main private sector mandates in Title I of H.R. 3070. The direct costs of those mandates consist of the additional health expenses that would be covered by insurance as a direct result of their implementation. Expenses for pre-existing conditions that would have to be paid by insurers under the bill but would not have been insured under current law, for example, are included in aggregate direct costs. In contrast, insured expenses that would be transferred among dif-

ferent insurers because of the bill are not included in aggregate direct costs.

In making this estimate, CBO did not attempt to value any social benefits that might result from expansions in insurance coverage. That is, the estimate accounts only for the additional insurance costs of the mandates, not the value of additional insurance coverage to beneficiaries. Nor was there an attempt to quantify any indirect costs or benefits. Such indirect effects could include, for example, loss of coverage if an employer ceases to offer group coverage when premiums rise, or increases in worker mobility (or reduced "job lock") with greater portability of benefits. It would be important to weigh all such factors in considering the bill, but only estimates of the direct costs of the mandates in the bill are required by P.L. 104–4, the Unfunded Mandates Reform Act.

Direct costs of mandates on group insurers and employee health benefit plans

Two of the principal mandates in H.R. 3070 affect group and employee health benefit plans: (1) limiting the maximum length of pre-existing condition exclusions, and (2) requiring that health plans reduce the length of pre-existing condition exclusions for people with prior continuous coverage under other health plans. CBO estimates that the direct cost of those two mandates would total about $300 million in each of the first five full years the provisions would be effective. This cost is approximately 0.2 percent of the total premium payments in the group and employer-sponsored market.

Limiting the maximum length of an exclusion

The mandate to limit exclusions for pre-existing conditions to 12 months (18 months for late enrollees) is estimated to have a direct private-sector cost of about $200 million per year. This estimate is based on two components: (1) the number of people who would have more of their medical expenses covered by insurance if exclusions were limited to one year or less, and 2) the average cost to insurers of that newly insured medical care.

CBO used data from the Survey of Employee Benefits in the April 1993 Current Population Survey (CPS) to estimate the number of people with conditions that are not now covered because of a pre-existing condition exclusion of more than one year. The survey asks respondents whether they or a family member have a medical condition that their employment-based plan is not covering because of a pre-existing condition exclusion. It also asks respondents how long they have been with their present firm. For people with medical conditions excluded by a pre-existing condition clause, responses to the second question are used to estimate whether the exclusion period exceeds one year.

A number of adjustments were made to the data. In particular, CBO's estimate of the number of people affected by H.R. 3070 excluded people who said they were limited by a pre-existing restriction but who also had other health insurance coverage, because the other insurance plan might have covered their pre-existing condition. Under those circumstances, the limitation imposed on employ-

ment-based plans by H.R. 3070 would not raise their aggregate costs.

A second modification to the CPS data adjusted for changes in the insurance market that have occurred since the survey date of 1993. In particular, since that time, about 40 states have implemented laws affecting the small group insurance market that would limit pre-existing condition exclusions to one year or less and require that previous coverage be credited against those exclusions. Those laws generally apply to groups of 50 or fewer employees and do not include self-funded health benefit plans. Because plans covered by such state laws would not have to change their provisions as a result of H.R. 3070, CBO lowered its initial estimate of the number of people affected by the bill.

CBO's analysis led to the conclusion that approximately 300,000 people would gain coverage under H.R. 3070 for some condition that would otherwise be excluded by a long (more than one year) pre-existing condition clause. This estimate represents less than 0.3 percent of people with private employment-based coverage.

The other component of the estimated private-sector cost is the average cost of the coverage that would become available under H.R. 3070. A recent monograph from the American Academy of Actuaries (referred to as the Academy) indicated a surge in claims costs of 40 to 60 percent when a pre-existing condition exclusion period expired for a sample of people with high expected medical costs.[1] That range is consistent with information from Spencer and Associates indicating that the costs of policies for former employees who have chosen to take extended COBRA coverage are 55 percent higher than those of active employees.[2] Applying those percentages to the average premium cost in the employer-sponsored market yields additional costs of about $900 a year per person who would gain coverage under H.R. 3070.

Crediting prior coverage against current exclusions

Another provision in H.R. 3070 would require insurers under certain circumstances to credit previous continuous health insurance coverage against pre-existing condition periods. That provision is estimated to have a private sector cost of about $100 million per year. The key components of this estimate are: (1) the number of people who would receive some added coverage, and (2) the additional full-year cost of coverage, adjusted to reflect the estimated number of months of that coverage.

CPS data were used to estimate the number of people who would receive some added coverage under this mandate. These are people who would otherwise face some denial of coverage under a pre-existing condition exclusion period of one year or less, and who would qualify for a shortened exclusion period based on prior continuous coverage. CBO estimates that about 100,000 people would receive some added coverage under this provision of the bill. The relatively small size of this estimate is due largely to the difficulty of meeting the restrictive eligibility criteria for the reduction in the exclusion

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[1] See American Academy of Actuaries, "Providing Universal Access in a Voluntary Private-Sector Market," February 1996.

[2] Charles D. Spencer and Associates, Inc. "1995 COBRA Survey: Almost One in Five Elect Coverage, Cost is 155% of Actives' Cost," Spencer's Research Reports (August 25, 1995).

period—particularly the requirement that at most a 60-day gap separate prior periods of insurance coverage from enrollment in the new plan.

The average number of months of coverage these people would gain is constrained by the one-year limit on the exclusion period that would be required under the bill. Based on information from a 1995 study by KPMG Peat Marwick, CBO estimates that people who would qualify would gain coverage for an average of 10 months.[3]

CBO's estimate of the additional insured costs per person is based on evidence from the Academy, which suggested that people with pre-existing condition exclusions may not seek treatment during the exclusion period but have rapid increases in expenses when that period expires. That behavior would reduce the effectiveness of exclusion period in protecting insurers from treatment costs. The shorter the exclusion period the less effective the pre-existing condition exclusion is at reducing the insurer's costs. CBO consequently assumed that full-year insured costs of people getting coverage for pre-existing conditions under this provision would rise by less than 40 percent.

Other considerations

The estimated direct cost of the mandate to limit the length of pre-existing condition exclusions is about $200 million annually, and the cost of the mandate to credit previous coverage against pre-existing condition exclusions is about $100 million. Together, those mandate costs amount to about 0.2 percent of total premium payments in the group and employer-sponsored market.

Those estimates are subject to considerable uncertainty for several reasons. First, they are based on individuals' responses to surveys, which should be treated with caution. In addition, unforeseen changes in health insurance markets could result in the estimates being too low or too high. Larger than expected increases in medical costs would result in higher direct costs than estimated. On the other hand, the growth of managed care plans would lower the direct costs of the bill. The magnitude of this effect would depend on the relative growth of HMOs, which generally do not use preexisting condition exclusions, as compared to PPO and POS plans, many of which do use preexisting condition exclusions.

The distribution of the direct costs of the mandates would be uneven across health plans. Only plans that currently use pre-existing condition exclusions of more than 12 months would face the $200 million direct cost of the first mandate. Data from the Peat Marwick survey indicate that 2.5 percent of employees are in such health plans. Consequently, the costs of health plans that use long pre-existing exclusions would be about 4.5 percent of their premium costs. Likewise, only health plans that use pre-existing condition exclusions would face the direct cost of the mandate to credit previous coverage against the pre-existing condition exclusion. The data indicate that almost half of employees are in such plans—implying that the plans directly affected by this mandate would have

[3] Based on unpublished tabulations from KPMG Peat Marwick, LLP, Survey of Employer-Sponsored Benefits, 1995.

direct costs equal to about one-tenth of one percent of their premiums under current law.

Employers could respond in a number of ways to the additional insured costs that would arise under these provisions of the bill. They could reduce other insurance benefits, increase employees' premium contributions, or reduce other components of employee compensation. Employers would be likely to respond in different ways, and these changes could take time. Some employers that currently offer health insurance to their employees might drop that coverage if the costs became too large, although the magnitude of such a reaction would probably be modest. These employer responses, which would redistribute the costs of the mandates, are indirect effects and do not enter into CBO's estimates of the direct costs to the private sector of the insurance mandates.

Direct costs of mandates affecting the individual insurance market

H.R. 3070 would require issuers of individual health insurance policies to offer coverage to all people who have had group or employer-sponsored coverage continuously for at least 18 months immediately prior to enrolling, but who are not eligible for additional COBRA or other group coverage. CBO estimates that this group-to-individual portability provision would impose aggregate direct costs on the private sector of less than $50 million in the first year the law was effective. Those aggregate direct costs would rise to about $200 million annually in the fifth year.

The mandate costs are added insurance costs of people who would gain coverage minus premium payments that the newly covered individuals themselves would make to insurers. Premium payments are subtracted because they would directly offset part of the cost of the mandate imposed on insurers.

A key element of this estimate is the calculation the number of people who would both qualify for and desire to purchase individual market insurance under the provisions in H.R. 3070, but who would not be extended insurance coverage under current law. CBO analyzed data from the 1992 Survey of Income and Program Participation (SIPP) to determine the number of people who: (1) had 18 months of prior continuous group coverage, and (2) would purchase an individual policy if insurers were not permitted to exclude them on the basis of health. We assumed that uninsured survey respondents who indicate that they were too sick to obtain insurance would fulfill the latter condition. The data suggest, however, that only about 25 percent of such people would meet H.R. 3070's requirement of 18 months of continuous prior group coverage.

Because the SIPP survey used in this analysis ended in late 1993, we made two additional adjustments to our estimate. First, we corrected for changes in the number of uninsured since 1993. Second, we reduced our estimate to account for state legislation that supersedes the H.R. 3070 provision. Many states undertook reforms of their individual insurance markets prior to the time of the survey, and a few additional states have implemented such laws since then. We assumed that all states with comparable laws would get waivers from the H.R. 3070 provisions affecting the individual market. Accordingly, the estimate assumes that the mandate would only be effective in states accounting for about 5.4 million of the

estimated 13.4 million people currently having individual coverage.[4] (Note that estimates of the Number of people insured through the individual market vary considerably. CBO's assumption is consistent with that of the Academy.)

CBO concludes that approximately 45,000 people would become covered by the end of the first year the bill would be effective because of the group-to-individual portability provision. The number of covered people would grow gradually over time as more people who, in the absence of H.R. 3070, would have been denied coverage because of poor health would meet the 18-month continuous group coverage requirement and choose to purchase individual insurance. In about four years, the number of people covered because of those portability provisions would plateau at around 150,000 people. Those estimates refer only to the number of people who gain insurance coverage as a result of H.R. 3070. The estimates do not included people who might decide to move into individuals insurance coverage under H.R. 3070 but would have had insurance coverage from elsewhere in the absence of the bill. It would not be appropriate to count such people toward the aggregate direct costs of the bill because their medical expenses would have been insured anyway.

In order to complete the estimate, we calculated the direct mandate costs per person who would obtain individual coverage because of this bill. Those costs equal the difference between the added insurance costs of the people who would gain coverage and the premium payments that those newly covered people would make to insurers. Neither the additional insurance costs, nor the additional premium revenue, can be estimated with a high degree of confidence.

H.R. 3070 would prohibit the denial of coverage because of health status or claims experience. Consequently, people gaining coverage through the portability provisions of H.R. 3070 would cost more, on average, than the typical person who currently purchases an individual policy. But, because of the multiple eligibility criteria required by H.R. 3070, surveys of health expenditures do not provide an adequate basis for a specific estimates of those higher costs.

Likewise, the premiums that insurers might charge newly covered people are highly uncertain because they depend on the unknown responses of state insurance regulators that are likely to vary among the states. At one extreme, state regulators might not allow insurers to charge higher premiums for people qualifying under the H.R. 3070 portability provision. The loss on those people would then be relatively large. At the other extreme, state regulators might allow insurers to charge them their full expected costs. In that case, there would be no loss to insurers, and consequently no aggregate costs from that mandate.

Previous studies offer divergent views on these issues. The Academy assumed that people obtaining individual coverage through the portability provisions would have costs two to three times as high as standard risks.[5] They also assumed that the premiums

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[4] Calculations based on consultations with the Congressional Research Service/Hay Group concerning state individual insurance market laws.

[5] American Academy of Actuaries, "Comments on the Effect of S. 1028 of Premiums in the Individual Health Insurance Market," February 20, 1996.

those people would pay would range from 125 to 167 percent of the average individual premium. That is, the Academy assumed that states would limit what insurers could charge to less than the full cost of the benefit.

The Health Insurance Association of America (HIAA) assumed that newly covered people who exhausted their COBRA coverage would have costs between two and three times the average, while the cost of those not eligible for COBRA coverage would be 1.5 to two times the average.[6] HIAA made no specific assumptions about the rating rules that states would impose on health plans in the individual market.

Although neither the costs not the insurance premiums associated with the newly covered individuals are known, it is not unreasonable to assume that state insurance commissioners would take the additional costs, and their potential effects, into account in regulating the individual market. If, for example, the expected costs of the newly insured people were high relative to others in the individual market, insurance regulators might allow insurers to charge such people relatively high premiums. Conversely, if the expected costs of the newly insured people were not much higher than others in the individual market, state regulators might not allow their premiums to deviate much from the market average.

This relationship can be viewed in terms of a target "loss" percentage that regulators might seek. That percentage would be the difference between the cost of coverage and the premium, expressed as a share of the average premium in the individual market. Based on a wide range of possible cost and premium factors, CBO assumed that the insurers' loss percentage associated with the newly covered individuals would be about 70 percent. That is, the difference between premium income and insurance costs for the newly insured people is expected to be about 70 percent of the average premium paid by others in the individual market.

Multiplying the loss percentage by the average individual market premium under current law and by the number of newly covered people yields the estimated aggregate direct costs of the group-to-individual portability provision. Those costs are expected to be less than $50 million in the first effective year of the legislation and to rise to about $200 million annually be the fifth year.

Other considerations

For those states in which the individual market mandates are expected to apply, premiums are estimated to be around 0.5 percent higher than otherwise by the end of the first year of implementation and to be approximately 2 percent higher than otherwise by the end of the fifth year. Those premium increases represent the excess costs that presumably would be passed on to people who would have acquired individual policies in the absence of this bill. The estimates of premium increases are limited to those costs attributable to people who obtain insurance in the individual market who would have been uninsured in the absence of H.R. 3070.

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[6] Health Insurance Association of America, "The Cost of Ending 'Job Lock' or How Much Would Health Insurance Costs Go Up if 'Portability' of Health Insurance Were Guaranteed: Preliminary Estimates," July 26, 1995.

If individual insurance premiums rose sufficiently as a consequence of H.R. 3070, some people with individual coverage would probably drop their insurance. Those most likely to do so would be lower-income people who were not in poor health. CBO used an analysis by Marquis and Long to estimate the number of people who would drop out of the individual insurance market in response to higher premiums.[7] By the fifth year after H.R. 3070 became effective, about 35,000 people who would have purchased individual policies in the absence of this legislation would not do so. Overall, however, the number of people with insurance in the individual market would probably rise as a result of H.R. 3070.

CBO's estimate assumes that states that already meet the individual market standards in H.R. 3070 would elect to maintain their own regulatory programs to guarantee insurance availability in the individual market. Mechanisms that would qualify states to avoid federal regulation include guaranteed issue laws and state-sponsored risk pools to provide insurance for high-risk people. The Academy has suggested, however, that states might choose not to continue such programs. States might see the provisions of H.R. 3070 as a mechanism to transfer some individuals out of partially state-subsidized high-risk insurance pools into the private market, where their additional costs would be picked up entirely by the private sector.

7. Appropriations or other Federal financial assistance: None.

8. Previous CBO estimate: CBO has prepared cost estimates of various other health care reform bills—S. 1028 as reported by the Senate Committee on Labor and Human Resources on October 12, 1995, and H.R. 3103 as reported by the House Committee on Ways and Means on March 19, 1996. All three bills have similar pre-existing condition and portability provisions affecting the group health insurance market, but they differ in other respects. For example, the Senate and Commerce Committee bills both include provisions for group-to-individual portability, which H.R. 3103 does not have. In addition, S. 1028 includes provisions to guarantee availability of insurance to employers, and H.R. 3070 has provisions to guarantee availability in the small group market only. The Ways and Means Committee bill, by contrast, has no provisions to guarantee availability. It is also the only one of the three bills to include provisions promoting the use of medical savings accounts and modifying the Internal Revenue Code in various other ways.

9. Estimate prepared by: James Baumgardner.

10. Estimate approved by: Joseph Antos, Assistant Director for Health and Human Resources.

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee finds that the bill would have no inflationary impact.

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[7] M. Susan Marquis and Stephen H. Long, "Worker Demand for Health Insurance in the Non-Group Market," Journal of Health Economics, vol. 14, no. 1 (May 1995), pp. 47–63.

ADVISORY COMMITTEE STATEMENT

Pursuant to section 5(b) of the Federal Advisory Committee Act, the Committee notes that the new advisory committee created by this legislation is necessary and that its functions could not be performed adequately by an existing advisory committee authorized under the Social Security Act or by enlarging the mandates of an existing advisory committee authorized under such Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Title I.—Improved Availability and Portability of Health Insurance Coverage

Subtitle A—Coverage Under Group Health Plans

Portability of coverage

This title would ensure the portability of health insurance for individuals moving from one source of group health coverage to another. Under the provision:

Group health plans, insurers, and health maintenance organizations would be prohibited from imposing a preexisting condition exclusion that exceeded 12 months for conditions for which medical advice, diagnosis, or treatment was received or recommended within the previous 6 months prior to becoming insured. In the event that the individual was a late enrollee, the preexisting condition exclusion could not exceed 18 months for conditions arising within 6 months prior to becoming insured.

Preexisting condition exclusions or limitations could not be applied to newborns and adopted children so long as these individuals became insured within 30 days of birth or placement for adoption. Pregnancy could not be treated as a preexisting condition. In addition, genetic information could not be considered a preexisting condition, so long as treatment of the condition to which the information was applicable had not been sought during the 6 months prior to becoming covered.

Group health plans, insurers, and health maintenance organizations (HMOs) would be required to credit periods of qualified previous coverage toward the fulfillment of a preexisting condition exclusion period when an individual moved from one source of group health coverage to another. Specifically, a preexisting condition limitation period would be reduced by the length of the aggregate period of any qualified prior coverage. Prior coverage would not have to be credited toward a preexisting condition limitation period if the individual experienced a break in qualified group coverage of more than 60 days. (Qualified group coverage means any period of coverage of the individual under a group health plan, health insurance coverage, Medicaid, Medicare, military health care, the Indian Health Service, State health insurance coverage or State risk pool, and coverage under the Federal Employee Health Benefits Program (FEHBP).) A waiting period for any coverage under a group health plan (or for health insurance coverage offered in connec-

tion with a group health plan) would not be considered a break in coverage.

Presentation of a certification of prior coverage would establish an individual's eligibility for credit against a preexisting condition limitation period. Group health plan administrators, insurers, HMOs, and State Medicaid programs would be required to provide such certifications of coverage upon request of the individual.

In determining whether an individual has met qualified coverage periods, a group health plan, insurer, or HMO offering group coverage could elect one of two methods. Under the first, it could include all periods, without regard to the specific benefits offered during the period of prior coverage. Under the second, it could look at periods of prior coverage on a benefit-specific basis and not include as a qualified coverage period a specific benefit unless coverage for that benefit was included at the end of the most recent period of coverage. Entities electing the second method would have to state prominently in any disclosure statements concerning the plan or coverage and to each enrollee at the time of enrollment or sale that the plan or coverage had made such an election and would have to include a description of the effect of this election. Upon the request of the plan, insurer, or HMO, the entity providing the certification would have to promptly disclose information on benefits under its plan. It could charge a reasonable cost for providing this information.

Availability of coverage

The bill would ensure that individuals in group health plans could not be excluded from coverage or from renewing their coverage based on their health status. Health status is defined to include, with respect to an individual, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

Group health plans would be required to provide for special enrollment periods for eligible individuals who lose other sources of coverage if certain conditions were met. An individual would have to be allowed to enroll under at least one benefit option if: (1) the employee (or dependent) had been covered under another group health plan at the time coverage was previously offered, (2) that this was the reason for declining enrollment, (3) that the individual lost their coverage as a result of certain events (loss of eligibility for coverage, termination of employment, or reduction in the number of hours of employment), and (4) the employee requested such enrollment within 30 days of termination of the coverage.

In the event that a group health plan provided family coverage, the plan could not require, as a condition of coverage of a beneficiary or participant in the plan, a waiting period applicable to the coverage of a beneficiary who is a newborn, an adopted child or child placed for adoption, or a spouse, at the time of marriage, if the participant has met any waiting period applicable to that participant. The bill defines timely enrollment as being within 30 days

of the birth, adoption, or marriage if family coverage was available as of that date.

Enforcement

The above provisions would be enforced through penalties assessed through the Internal Revenue Code (IRC), Employee Retirement Income Security Act (ERISA), or through civil money penalties assessed by the Secretary of Health and Human Services (HHS). The Secretaries of Treasury, Labor, and HHS would be required to issue regulations that were nonduplicative and in a manner that assured coordination and nonduplication in their activities as provided for under this Act.

Enforcement through the IRC

IRC enforcement would be done through the Consolidated Omnibus Budget Reconciliation Act (COBRA) health insurance continuation provisions (section 4980B). In general, a noncomplying plan would be subject to an excise tax of $100 per day per violation. Penalties would not be assessed in the event that the failure was determined to be unintentional or a correction was made within 30 days. For purposes of applying the COBRA enforcement language, special rules would apply:

No tax could be imposed by this provision on a noncomplying insurer or HMO subject to State insurance regulation if the Secretary of HHS determined that the State had an effective enforcement mechanism.

In the case of a group health plan of a small employer that provided coverage solely through a contract with an insurer or HMO, no tax would be imposed upon the employer if the failure was solely because of the product offered by the insurer or HMO.

No tax penalty would be assessed for a failure under this provision if a sanction had been imposed under ERISA or by the Secretary of HHS with respect to such failure.

Enforcement through ERISA

Enforcement on certain group health plans would also be through ERISA sanctions. Such sanctions would only apply to an insurer or HMO that was subject to State law in the event that the Secretary of Labor determined that the State had not provided for effective enforcement of the above provisions of this Act. Sanctions would not apply in the event that the Secretary of Labor established that none of the persons against whom the liability would be imposed knew or, exercising reasonable diligence, would have known that a failure existed, or if the noncomplying entity acted within 30 days to correct the failure. In no case would a civil money penalty be imposed under ERISA for a violation for which an excise tax under the COBRA enforcement provisions was imposed or for which a civil money penalty was imposed by the Secretary of HHS.

Enforcement through civil money penalties

A group health plan, insurer, or HMO that failed to meet the above requirements would be subject to a civil money penalty.

Rules similar to those imposed under the COBRA penalties would apply. The maximum amount of penalty would be $100 for each day for each individual with respect to which a failure occurred. In determining the penalty amount, the Secretary would be required to take into account the previous record of compliance of the person being assessed with the applicable requirements of the bill, the gravity of the violation, and the overall limitations for unintentional failures provided under the IRC COBRA provisions. No penalty could be assessed if the failure was not intentional or if the failure was corrected within 30 days. A procedure would be available for administrative and judicial review of a penalty assessment. Any penalties collected would be paid to the Secretary and would be available without appropriation for the purpose of enforcing the provisions with respect to which the penalty was imposed.

The authority for the Secretary of HHS to impose civil money penalties would not apply to enforcement with respect to any entity which offered health insurance coverage and which was an insurer or HMO subject to State regulation by an applicable State authority if the Secretary of HHS determined that the State had established an effective enforcement plan. In no case would a civil money penalty be imposed under this provision for a violation for which an excise tax under COBRA or civil money penalty under ERISA was assessed.

Subtitle B—Certain Requirements for Insurers and HMOs in the Group and Individual Markets

PART 1. AVAILABILITY OF GROUP HEALTH INSURANCE COVERAGE

Guaranteed availability

The bill would provide for guaranteed availability of general coverage in the small group market. Each insurer or HMO that offered general coverage in the small group market in a State would have to: accept every small employer in the State that applied for such coverage; and accept for enrollment under such coverage every eligible individual who applied for enrollment during the initial enrollment period in which the individual first became eligible for coverage under the group health plan. No exclusions could be placed on the coverage of an eligible individual based on health status.

The small group market is generally defined as employer groups with more than 2 and less than 51 employees. An eligible individual is one in relation to the employer as determined: (1) in accordance with the terms of the plan; (2) as provided by the insurer or HMO under rules which would have to be applied uniformly; and (3) in accordance with applicable State laws. Special rules would apply to network plans and HMOs to ensure that this guaranteed availability provision did not lead to capacity problems. In addition, such entities would not have to enroll a small group whose employees worked or lived outside the entity's service area. Insurers and HMOs could deny enrollment to an eligible small group in the event that the group failed to meet certain minimum participation or contribution requirements that were consistent with State law.

Guaranteed renewability

The bill would provide for guaranteed renewability of group coverage. If an insurer or HMO offered health insurance coverage in the small or large group market, the coverage would have to be renewed or continued in force at the option of the employer. (An insurer or HMO could modify the coverage offered to a group health plan so long as the modification was effective on a uniform basis among group health plans with that type of coverage.) Exceptions to the guaranteed renewability requirement would apply in the event that the employer failed to pay the premiums, committed fraud, violated the participation rules, or moved outside the service area. In addition, guaranteed renewability would not apply if: (a) the insurer or HMO ceased to offer any such coverage in a State (or in the case of a network plan, in a geographic area); (b) in the event that the insurer or HMO uniformly terminated offering a particular type of coverage and provided adequate notice and the opportunity to elect other health insurance being offered in that market; and (c) in the event that the entity discontinued offering all health insurance coverage in the small or large group market or in both markets in a State, provided for adequate notice. In the last instance, such an entity could not re-enter the market it left for at least 5 years.

PART 2. AVAILABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE

This provision would ensure portability of health insurance for individuals moving from qualified group coverage to individual coverage.

The goals of this provision are to: (1) guarantee that any qualifying individual is able to obtain qualifying health insurance coverage and (2) to assure that qualifying individuals obtaining coverage receive credit for their prior coverage toward the new coverage's preexisting condition exclusion period (if any). Credit for previous qualified group coverage (and certification of such prior coverage) would work the same way as described above with respect to group-to-group portability.

A qualified individual means an individual who was in a qualified coverage period that included coverage under one or more group health plans which commenced 18 or more months before the date on which the individual was seeking individual insurance. This individual could not be eligible for coverage under a group health plan, Medicare, or Medicaid, and if eligible for COBRA continuation coverage (or a similar State continuation of coverage program) would have to have elected and exhausted such coverage. In addition, an individual would not be qualified if he or she was terminated from group coverage for cause (e.g., nonpayment of premiums or fraud). Qualifying coverage means, with respect to an insurer or HMO, individual health insurance coverage which meets certain requirements relating to the actuarial value of the benefits.

States would have the option of establishing mechanisms to achieve the bill's goals of guaranteeing availability of coverage. In general, any State could establish public or private mechanisms reasonably designed to meet the availability goals. If a State implemented such a mechanism by July 1, 1997 (or July 1, 1998 where

its legislature will not meet between January 1, 1997 and June 30, 1997), it could elect to have this mechanism apply instead of Federal law as implemented through the fallback described below. A State would elect this option by providing for timely notice to the Secretary of HHS. State mechanisms could include (but would not be limited to): (1) health insurance coverage pools or programs authorized or established by the State; (2) mandatory group conversion policies; (3) open enrollment by one or more issuers or HMOs; and (4) guaranteed issue by one or more plans of individual health insurance coverage to qualifying individuals. A State could continue an existing availability mechanism or could implement a new guaranteed availability mechanism prior to the dates specified above. A safe harbor would be provided in the case of States with health insurance coverage pools or risk pools in effect on March 12, 1996 whose benefits met the standard specified in the Act.

Recognizing that regulation of health insurance, particularly individual insurance, is primarily a State function, the Committee intends that States should have the maximum flexibility in determining how best to achieve group-to-individual portability within their borders. The Committee intends that the Secretary will give great deference to States' decisions in this regard.

If a State did not elect to implement its own availability mechanism before the deadlines indicated above, or if the Secretary, after consultation with the State's chief executive office and insurance commissioner, found that a State's mechanism was not reasonably designed to meet the availability goals of the Act, the Secretary would notify the State of such. If, after notice and an opportunity to change or implement a mechanism the State still did not have one in place, Federal guaranteed availability requirements would apply: an insurer or HMO in a State issuing individual health insurance coverage would have to offer qualifying health insurance coverage to each qualifying individual in the State and could not decline to issue such coverage based on health status. Such qualifying coverage would have to credit prior coverage toward the new coverage's preexisting condition exclusion (if any) consistent with the rules for crediting prior coverage described above. Exceptions to this requirement would apply in the event of network plan capacity limits. Nothing in this provision would affect the determination of an insurer or HMO as to the amount of the premium payable under an individual health insurance coverage under applicable State law.

An insurer or HMO providing health insurance coverage to an individual would have to renew or continue such coverage at the option of the individual. Nonrenewal would be permitted for cause (e.g., nonpayment of premiums and fraud). Insurers and HMOs could terminate coverage or plans consistent with the termination rules described for the group insurer market.

PART 3. ENFORCEMENT

Any State could establish a plan to enforce some or all of the requirements on insurers and HMOs in different health insurance markets in the State. If a State established such a plan and submitted it to the Secretary, the plan would apply with respect to re-

quirements, insurers, and HMOs instead of the Federal fallback enforcement provisions described above.

Subtitle C—Sense of the Committee on Additional Requirements

This subtitle provides that it is the sense of the Committee on Commerce that: (1) the impact on health care costs and the provision of necessary quality health care services of mandating inclusion in health insurance coverage of bone marrow transplants for treatment of breast cancer and of minimum periods of inpatient care for childbirth has not been evaluated; (2) there is no precedent for Congress requiring the coverage of specific benefits under private and State health insurance plans; and (3) it is the Committee's intent to hold one or more hearings to examine issues relating to requiring the inclusion of benefits under health insurance coverage offered in the group and individual markets.

Subtitle D—Definitions; General Provisions

In addition to providing definitions of terms used in this title of the Act, this subtitle provides for State flexibility to provide greater protection than required under the Act. Specifically, nothing in this bill should be construed to preempt State laws that: require insurers or HMOs to impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition period for a period that is shorter than the applicable period provided under this Act; or allow individuals, participants, and beneficiaries to be considered to be in a period of previous qualifying coverage if such individual, participant, or beneficiary experiences a lapse in coverage that is greater than the 60-day periods provided for under this Act, or in defining ''preexisting condition'' to have a look-back period that is shorter than 6 months.

Nothing in this Act shall be construed to affect or modify the provisions of section 514 of ERISA (relating to Federal preemption of laws regulating employee benefit plans).

Effective date

In general, except as otherwise provided for in this title, the provisions of this title would apply with respect to: (1) group health plans and health insurance coverage offered in connection with group health plans, for plan years beginning on or after January 1, 1998; and (2) individual insurance coverage issued, renewed, in effect, or operated on or after January 1, 1998.

The Secretaries of HHS, Treasury, and Labor would be required to issue regulations on a timely basis as may be required to carry out this title.

Rule of construction

Nothing in this title or any amendment made thereby may be construed to require the coverage of any specific procedure, treatment, or service as part of a group health plan or health insurance coverage under this title or through regulation.

TITLE II—PREVENTING HEALTH CARE FRAUD AND ABUSE; ADMINISTRATIVE SIMPLIFICATION

Subtitle A—Fraud and Abuse Control Program

Sec. 201. Fraud and abuse control program

Currently Medicare's program integrity functions are subsumed under Medicare's general administrative budget. These functions are performed, along with general claims processing functions, by insurance companies under contract with the Health Care Financing Administrative.

Fraud and abuse control program

Under Section 201, the Secretary of Health and Human Services (acting through the Office of the Inspector General) and the Attorney General would be required to jointly establish a national health care fraud and abuse control program to coordinate Federal, State and local law enforcement to combat fraud with respect to health plans. To facilitate the enforcement of this fraud and abuse control program, the Secretary and Attorney General would be authorized to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care, and would be required to arrange for the sharing of data with representatives of public and private third party payers. This program, implemented by guidelines issued by the Secretary and the Attorney General, would also facilitate the enforcement of applicable Federal statutes relating to health care fraud and abuse, and would provide for the provision of guidance to health care providers through the issuance of safe harbors, interpretive rulings, and special fraud alerts.

The Secretary and Attorney General would consult and share data with representatives of health plans. Guidelines issued by the Secretary and Attorney General would ensure the confidentiality of information furnished by health plans, providers and others, as well as the privacy of individuals receiving health care services. The Inspector General would retain all current authorities and would receive reimbursement for costs of investigations, audits and other functions under this section.

For purposes of this section, the term "health plan" means a plan or program that provides health benefits through insurance or otherwise. Such plans include health insurance policies, contracts of service benefit organizations, and membership agreements with health maintenance organizations or other prepaid health plans.

Establishment of health care fraud and abuse control account in federal hospital insurance trust fund

The Health Care Fraud and Abuse Control Account would be established as an expenditure account within the Federal Hospital Insurance (HI) Trust Fund. Monies derived from the coordinated health care anti-fraud and abuse programs from the imposition of civil money penalties, fines, forfeitures and damages assessed in criminal, civil or administrative health care cases, along with any gifts or bequests would be transferred into the Medicare HI trust fund. There are appropriated from the HI trust fund to the Account

such sums as the Secretary and the Attorney General certify are necessary to carry out certain functions, subject to specified limits for each fiscal year beginning with 1997.

There are also appropriated from the general fund of the U.S. Treasury to the Fraud and Abuse Account for transfer to the FBI certain funds, subject to fiscal year limitations, for specified functions. These functions include prosecuting health care matters, investigations, audits of health care programs and operations, inspections and other evaluations, and provider and consumer education regarding compliance with fraud and abuse provisions. Amounts in the Account would also be available to the various State Medicaid fraud control units to reimburse such units for the costs of certain activities. The Secretary and the Attorney General are required to submit a joint annual report to Congress on the revenues and expenditures, and the justification for such disbursements from the Health Care Fraud and Abuse Control Account.

Sec. 202. Medicare integrity program

Currently Medicare's program integrity functions are subsumed under Medicare's general administrative budget. These functions are performed, along with general claims processing functions, by insurance companies under contract with the Health Care Financing Administration.

Establishment of Medicare integrity program

Section 202 would establish a Medicare Integrity Program under which the Secretary would promote the integrity of the Medicare program by entering into contracts with eligible private entities to carry out certain activities. These activities would include the following: (1) review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under the Medicare program, including medical and utilization review and fraud review; (2) audit of cost reports; (3) determinations as to whether payment should not be, or should not have been, made by reason of Medicare as secondary payor provisions and recovery of payments that should not have been made; (4) education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues; and (5) developing and updating a list of durable medical equipment pursuant to section 1834(a)(15) of the Social Security Act.

Eligibility of entities

The Secretary would impose certain eligibility requirements on entities entering into contracts under this Medicare Integrity Program, including conflict of interest requirements.

The Secretary would be authorized to establish, by regulation, procedures for entering into contracts with eligible entities, including procedures relating to the number of contracts and the timing of contracts, competitive procedures for new contracts, and waiver of competitive procedures for renewed contracts under certain circumstances.

The Secretary would be required to provide, by regulation, for the limitation of a contractor's liability under the Medicare Integ-

rity Program. The Secretary would employ, to the extent he or she finds appropriate, the same or comparable standards and other substantive and procedural provisions as are contained in section 1157 of the Social Security Act.

Elimination of fiscal intermediary and carrier responsibility for carrying out activities subject to program

This provision prohibits any agency, organization, or carrier, from carrying out (or receiving payment for carrying out) any activity pursuant to an agreement under this section to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program.

Sec. 203. Beneficiary incentive programs

Clarification of requirement to provide explanation of Medicare benefits

The Secretary would be required to provide an explanation of Medicare benefits with respect to each item or service for which payment may be made, without regard to whether a deductible or coinsurance may be imposed with respect to the item or service.

Program to collect information on fraud and abuse

This provision would require the Secretary, within three months after enactment of this bill, to establish a program to encourage individuals to report to the Secretary information on individuals and entities who are engaging or who have engaged in acts or omissions that constitute grounds for sanctions under sections 1128, 1128A, or 1128B of the Social Security Act, or who have otherwise engaged in fraud and abuse against the Medicare program. If an individual reports information to the Secretary under this program that serves as a basis for the collection by the Secretary or the Attorney General of any amount of at least $100 (other than amounts paid as a penalty under section 1128B), the Secretary may pay a portion of the amount collected to the individual, under procedures similar to those applicable under section 7623 of the Internal Revenue Code of 1986.

Program to collect information on program efficiency

The Secretary would be required, within three months after enactment of this bill, to establish a program to encourage individuals to submit to the Secretary suggestions on methods to improve the efficiency of the Medicare program. If the Secretary adopts a suggestion and savings to the program result, the Secretary could make a payment to the individual of an amount the Secretary considers appropriate.

Sec. 204. Application of certain health anti-fraud and abuse sanctions to fraud and abuse against Federal health care programs

Under current law, section 1128B of the Social Security Act provides for certain criminal penalties for convictions of Medicare and Medicaid (and other State health care programs) program-related fraud.

Section 204 would extend certain criminal penalties for fraud and abuse violations under the Medicare and Medicaid programs to similar violations in Federal health care programs generally. The term "Federal health care program" would mean any plan or program that provides health benefits, whether directly, through insurance, or otherwise which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5, United States Code). The term also would include any State health care program, which under section 1128(h), includes Medicaid, the Maternal and Child Health Services Block Grant Program and the Social Services Block Grant Program.

Sec. 205. Guidance regarding application of health care fraud and abuse Sanctions

Guidance regarding application of health care fraud and abuse sanctions

The 1987 Medicare and Medicaid Patient and Program Protection Act specified various payment practices which, although potentially capable of including referrals of business under Medicare or State health care programs, are protected from criminal prosecution or civil sanction under the anti-kickback provisions of the law. The 1987 law also established authority for the Secretary to promulgate regulations specifying additional payment practices, known as "safe harbors," which will not be subject to sanctions under the fraud and abuse provisions.

Under Section 205, the Secretary would publish an annual notice in the Federal Register soliciting proposals for modifications to existing safe harbors and new safe harbors. After considering such proposals the Secretary, in consultation with the Attorney General, would issue final rules modifying existing safe harbors and establishing new safe harbors, as appropriate. The Inspector General would submit an annual report to Congress describing the proposals received, as well as the action taken regarding the proposals. The Secretary, in considering proposals, may consider a number of factors including the extent to which the proposals would affect access to health care services, quality of care services, patient freedom of choice among health care providers, competition among health care providers, ability of health care facilities to provide services in medically underserved areas or to medically underserved populations, and the like.

The Secretary of Health and Human Services would publish the first notice in the Federal Register soliciting proposals for new or modified safe harbors no later than January 1, 1997.

Advisory opinions

The Secretary shall issue written advisory opinions regarding (1) what constitutes prohibited remuneration under section 1128B(b); (2) whether an arrangement or proposed arrangement satisfies the criteria for activities which do not result in prohibited remuneration; (3) what constitutes an inducement to reduce or limit services to individuals entitled to benefits; and (4) whether an activity constitutes grounds for the imposition of a sanction under sections

1128, 1128A, or 1128B(b). Advisory opinions shall be binding as to the Secretary and the party requesting the opinion.

Special fraud alerts

Any person may request the Inspector General to issue a special fraud alert informing the public of practices which the Inspector General considers to be suspect or of particular concern under the Medicare program or a State health care program, as defined in section 1128(h) of the Social Security Act. After investigation of the subject matter of the request, and, if appropriate, the Inspector General shall issue a special fraud alert in response to the request, published in the Federal Register.

Subtitle B—Revisions to Current Sanctions for Fraud and Abuse

Sec. 211. Mandatory exclusion from participation in medicare and state health care programs

Section 1128 of the Social Security Act authorizes the Secretary to impose mandatory and permissive exclusions of individuals and entities from participation in the Medicare program, Medicaid program, and programs receiving funds under the Maternal and Child Health Services Block Grant or the Social Services Block Grant. Mandatory exclusions are authorized for convictions of criminal offenses related to the delivery of health care services under Medicare and State health care programs, as well as for convictions relating to patient abuse in connection with the delivery of a health care item or service. In the case of an exclusion under the mandatory exclusion authority, the minimum period of exclusion could be no less than five years, with certain exceptions. Permissive exclusions are authorized for a number of offenses relating to fraud, kickbacks, obstruction of an investigation, and controlled substances, and activities relating to license revocations or suspensions, claims for excessive charges or unnecessary services, and the like.

Individual convicted of felony relating to health care fraud

Section 211 would require the Secretary to exclude individuals and entities from Medicare and State health care programs who have been convicted of felony offenses relating to health care fraud for a minimum five year period. The Secretary would also retain the discretionary authority to exclude individuals from Medicare and State health care programs who have been convicted of misdemeanor criminal health care fraud offenses, or who have been convicted of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in programs (other than health care programs) funded in whole or part by any Federal, State or local agency.

Individual convicted of felony relating to controlled substance

This section would require the Secretary to exclude individuals and entities from Medicare and State health care programs who have been convicted of felony offenses relating to controlled substances for a minimum five year period. The Secretary would retain the discretionary authority to exclude individuals from Medicare

and State health care programs who have been convicted of misdemeanor offenses relating to controlled substances.

Effective date

This section would apply to convictions after the date of the enactment of this statute.

Sec. 212. Establishment of minimum period of exclusion for certain individuals and entities subject to permissive exclusion from medicare and state health care programs

Section 1128 of the Social Security Act authorizes the Secretary to impose mandatory and permissive exclusions of individuals and entities from participation in Medicare program, Medicaid program, and programs receiving funds under the Maternal and Child Health Service Block Grant or the Social Services Block Grant. Mandatory exclusions are authorized for convictions of criminal offenses related to the delivery of health care services under Medicare and State health care programs, as well as for convictions relating to patient abuse in connection with the delivery of a health care item or service. In the case of an exclusion under the mandatory exclusion authority, the minimum period of exclusion could be no less than five years, with certain exceptions. Permissive exclusions are authorized for a number of offenses relating to fraud, kickbacks, obstruction of an investigation, and controlled substances, and activities relating to license revocations or suspensions, claims for excessive charges or unnecessary services, and the like.

Section 212 would establish a minimum period of exclusion for certain permissive exclusions from participation in Medicare and State health care programs.

For convictions of misdemeanor criminal health care fraud offenses, criminal offenses relating to fraud in non-health care Federal or State programs, convictions relating to obstruction of an investigation of health care fraud offenses, and convictions of misdemeanor offenses relating to controlled substances the minimum period of exclusion would be three years, unless the Secretary determines that a longer or shorter period is appropriate, due to aggravating or mitigating circumstances.

For permissive exclusions from Medicare or State health care programs due to the revocation or suspension of a health care license of an individual or entity, the minimum period of exclusion would not be less than the period during which the individual's or entity's license was revoked or suspended.

For permissive exclusions from Medicare or State health care programs due to exclusions from any Federal health care program or State health care program for reasons bearing on an individual's or entity's professional competence or financial integrity, the minimum period of exclusion would not be less than the period the individual or entity is excluded or suspended from a Federal or State health care program.

For permissive exclusions from Medicare or State health care programs due to a determination by the Secretary that an individual or entity has furnished items or services to patients substantially in excess of the needs of such patients or of a quality which

fails to meet professionally recognized standards of health care, the period of exclusion would be not less than one year.

Sec. 213. Permissive exclusion of individuals with ownership or control interest in sanctioned entities

Section 1128 of the Social Security Act authorizes the Secretary to impose mandatory and permissive exclusions of individuals and entities from participation in the Medicare program, Medicaid program, and programs receiving funds under the Maternal and Child Health Services Block Grant or the Social Services Block Grant. Mandatory exclusions are authorized for convictions of criminal offenses related to the delivery of health care services under Medicare and State health care programs, as well as for convictions relating to patient abuse in connection with the delivery of a health care item or service. In the case of an exclusion under the mandatory exclusion authority, the minimum period of exclusion could be no less than five years, with certain exceptions. Permissive exclusions are authorized for a number of offenses relating to fraud, kickbacks, obstruction of an investigation, and controlled substances, and activities relating to license revocations or suspensions, claims for excessive charges or unnecessary services, and the like.

Entities owned, controlled, or managed by a sanctioned individual are already subject to permissive exclusion from participation in Medicare and State health programs by the Secretary. Under Section 213, an individual who has a direct or indirect ownership or control interest in a sanctioned entity and who knows or should know of the action constituting the basis for the conviction or exclusion, or who is an officer or managing employee of such an entity, may also be excluded from participation in Medicare and State health care programs by the Secretary if the entity has previously been convicted of an offense listed in Section 1129(a) or (b)(1), (2) or (3) or otherwise excluded from program participation. Under the new provision, the culpable individual would also be subject to program exclusion, even if not initially convicted or excluded.

Sec. 214. Sanctions against practitioners and persons for failure to comply with statutory obligations

Under current law, the Secretary of Health and Human Services has the authority to impose administrative sanctions against practitioners and persons who have failed to comply with certain statutory obligations relating to the quality of medical care rendered. Under current law, the Secretary may require, in cases involving medically improper or unnecessary health care services, that the practitioner or person pay the United States an amount up to $10,000 for each instance of medically improper or unnecessary health care services. In such cases, the practitioner or person would be permitted to continue to be eligible to receive reimbursement for health care services rendered to program beneficiaries.

Minimum period of exclusion for practitioners and persons failing to meet statutory obligations

Under section 214, the Secretary may exclude a practitioner or person for such period as the Secretary may prescribe, except that such period shall be not less than one year.

Repeal of "unwilling or unable" conditions for imposition of sanction

The Secretary, in making his determination that a practitioner or person should be sanctioned for failure to comply with certain statutory obligations relating to quality of health care, will no longer be required to prove that the individual was either unwilling or unable to comply with such obligations.

Sec 215. Intermediate sanctions for Medicare health maintenance organizations

Under current law, a contract between the Secretary of HHS and a Medicare Health Maintenance Organization (HMO) is generally for a one year term, with an option for automatic renewal. However, the Secretary may terminate any such contract at any time, after reasonable notice and an opportunity for a hearing, if the Medicare HMO has failed substantially to carry out the contract, or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the requirements of section 1876 of the Social Security Act, or if the Medicare HMO no longer substantially meets the statutory requirements contained in sections 1876(b), (c), (e) and (f) of the Social Security Act.

Application of intermediate sanctions for any program violations

Under section 215, the Secretary may terminate a contract with a Medicare Health Maintenance Organization (HMO) or may impose certain intermediate sanctions on the organization if the Secretary determines that the Medicare HMO has failed substantially to carry out the contract; is carrying out the contract in a manner substantially inconsistent with the efficient and effective administration of this section; or, if the Medicare HMO no longer substantially meets the statutory requirements contained in Sections 1876(b), (c), (e) and (f) of the Social Security Act.

If the basis for the determination by the Secretary that intermediate sanctions should be imposed on an eligible organization is other than that the organization has failed substantially to carry out its contract with the Secretary, then the Secretary may apply intermediate sanctions as follows: civil money penalties of not more than $25,000 for each determination if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract; civil money penalties or not more than $10,000 for each week of a continuing violation; and suspension of enrollment of individuals until the Secretary is satisfied that the deficiency has been corrected and is not likely to recur.

Whenever the Secretary seeks to either terminate a Medicare HMO contract or impose intermediate sanctions on such an organization, the Secretary must do so pursuant to a formal investigation

and under compliance procedures which provide the organization with a reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's adverse determination. In making a decision whether to impose sanctions, the Secretary is required to consider aggravating factors such as whether an entity has a history of deficiencies or has not taken action to correct deficiencies the Secretary has brought to its attention. The Secretary's compliance procedures must also include notice and opportunity for a hearing (including the right to appeal an initial decision) before the Secretary imposes any sanction or terminates the contract of a Medicare HMO, and there must not be any unreasonable or unnecessary delay between the finding of a deficiency and the imposition of sanctions.

Agreements with peer review organizations

Under this section, each risk-sharing contract with a Medicare HMO must provide that the organization will maintain a written agreement with a utilization and quality control peer review organization or similar organization for quality review functions.

Effective date

The amendments made by this section shall apply to the contract years beginning on or after January 1, 1997.

Sec. 216. Additional exception to anti-kickback penalties for discounting and managed care arrangements

The anti-kickback provision currently in Section 1128(b) contains several exceptions. These exceptions include (1) discounts or other reductions in price obtained by a provider of services or other entity under Medicare or a State health care program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under Medicare or a State health care program; (2) any amount paid by an employer to an employee for employment in the provision of covered items or services; (3) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities under specified conditions; (4) a waiver of any coinsurance under Part B of Medicare by a Federally qualified health care center with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act; and (5) any payment practice specified by the Secretary as a ''safe harbor'' exception.

Section 216 would add a new exception to the anti-kickback provisions allowing remuneration between an eligible organization under section 1876 and an individual or entity providing items or services pursuant to a written agreement between the organization and the individual or entity. Remuneration would also be allowed between an organization and an individual or entity if a written agreement places the individual or entity at substantial financial risk for the cost or utilization of the items or services which the individual or entity is obligated to provide. The risk arrangement may be provided through a withhold, capitation, incentive pool, per diem payment or other similar risk arrangement. This amendment would apply to acts or omissions occurring after January 1, 1997.

Sec. 217. Criminal penalty for the fraudulent disposition of assets in order to obtain medicaid benefits

Under section 1128B of the Social Security Act, upon conviction of a program-related felony, an individual may be fined not more than $25,000 or imprisoned for not more than five years or both.

Section 217 would add a new crime to the list of prohibited activities under section 1128B of the Social Security Act for cases where a person knowingly and willfully disposes of assets by transferring assets in order to become eligible for benefits under a State health care program, including the Medicaid program, if disposing of the assets results in the imposition of a period of ineligibility.

Sec. 218. Effective date

Except as otherwise provided, the amendments made by this subtitle shall take effect January 1, 1997.

Subtitle C—Data Collection

Sec. 221. Establishment of the Health Care Fraud and Abuse Data Collection Program

In General

The Secretary of Health and Human Services is required to establish a national health care fraud and abuse data collection program for reporting final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners.

Each government agency and health plan would, on a monthly basis, report any final adverse action taken against a health care provider, supplier, or practitioner. Certain information would be included in the report, including a description of the acts or omissions and injuries upon which the final adverse action was taken. The Secretary would, however, protect the privacy of individuals receiving health care services.

The Secretary would, by regulation, provide for disclosure of the information about adverse actions, upon request to the health care provider, supplier, or licensed practitioner and provide procedures in the case of disputed accuracy of the information. Each government agency and health plan is required to report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner in such form and manner that the Secretary prescribes by regulation.

The information in the database would be available to Federal and State government agencies and health plans. The Secretary may approve reasonable fees for the disclosure of information in the database (other than with respect to requests by Federal agencies). The amount of such a fee shall be sufficient to recover the full costs of operating the database.

No person or entity would be held liable in a civil action with respect to any report made as required by this section, unless the person or entity knows the information is false. The definition for "final adverse action" and other related terms are specified in this section.

Improved prevention in issuance of medicare provider numbers

The Secretary may impose appropriate fees on physicians to cover the cost of investigation and recertification activities with respect to the issuance of identifiers for physicians who furnish services for which Medicare payments are made.

Subtitle D—Civil Monetary Penalties

Sec. 231. Social Security Act civil monetary penalties

Section 1128 of the Social Security Act authorizes the Secretary to impose mandatory and permissive exclusions of individuals and entities from participation in the Medicare program, Medicaid program, and programs receiving funds under the Maternal and Child Health Services Block Grant or the Social Services Block Grant. Mandatory exclusions are authorized for convictions of criminal offenses related to the delivery of health care services under Medicare and State health care programs, as well as for convictions relating to patient abuse in connection with the delivery of a health care item or service. In the case of an exclusion under the mandatory exclusion authority, the minimum period of exclusion could be no less than five years, with certain exceptions. Permissive exclusions are authorized for a number of offenses relating to fraud, kickbacks, obstruction of an investigation, and controlled substances, and activities relating to license revocations or suspensions, claims for excessive charges or unnecessary services, and the like.

Under Section 1128A of the Social Security Act, civil monetary penalties may be imposed for false and fraudulent claims for reimbursement under the Medicare and State health care programs.

Under section 1128B, upon conviction of a program-related felony, an individual may be fined not more than $25,000 or imprisoned for not more than five years, or both.

General civil monetary penalties

This section provides that the provisions under the Medicare and Medicaid programs which provide for civil money penalties for specified fraud and abuse violations would apply to similar violations involving other Federal health care programs. Federal health care programs would include any health insurance plans or programs funded, in whole or part, by the Federal government, such as CHAMPUS and FEHBP.

Civil money penalties and assessments received by the Secretary would be deposited into the Health Care Fraud and Abuse Control Account established under this Act.

Excluded individual retaining ownership or control interest in participating entity

Any person who has been excluded from participating in Medicare or a State health care program and who retains a direct or indirect ownership or control interest in an entity that is participating in a program under Medicare or a State health care program, and who knows or should know of the action constituting the basis for the exclusion, or who is an officer or managing employee of such

an entity would be subject to a civil money penalty of not more than $10,000 for each day the prohibited relationship occurs.

Modification of amounts of penalties and assessments

This section would amend the civil money penalty provisions of Section 1128A(a) by increasing the amount of a civil money penalty from $2,000 to $10,000 for each item or service involved. This section also increases the assessment which a person may be subject to from "not more than twice the amount" to "not more than three times the amount" claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim.

Claim for item or service based on incorrect coding or medically unnecessary services

This section would add two practices to the list of prohibited practices for which civil money penalties may be assessed. The first occurs when a person engages in a pattern or practice of presenting a claim for an item or service based on a code that the person knows or should know will result in greater payments than appropriate. The second is the practice whereby a person submits a claim that the person knows or should know is for a medical item or service which is not medically necessary.

The sanction against practitioners and persons who fail to comply with certain statutory obligations is changed from an amount equal to "the actual or estimated cost" of the medically improper or unnecessary services provided, to "up to $10,000 for each instance of medical improper or unnecessary services provided".

Procedural provisions

The procedural provisions outlined in Section 1128A, such as notice, hearings, and judicial review rights shall apply to civil money penalties assessed against Medicare Health Maintenance Organizations in the same manner as they apply to civil money penalties assessed against health care providers generally.

Prohibition against offering inducements to individuals enrolled under programs or plans

This section would add a new practice to the list of prohibited practices for which civil money penalties may be assessed. Any person who offers remuneration to an individual eligible for benefits under Medicare or a State health program that such individual knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner or supplier any item or service reimbursable under Medicare or a State health care program, shall be subject to the various civil money penalties, assessments and exclusion provisions of section 1128A of the Social Security Act.

The term "remuneration" is defined to include the waiver of part or all of coinsurance and deductible amounts, as well as transfers of items or services for free, or for other than fair market value. There are exceptions to this definition. The waiver of part or all of coinsurance and deductible amounts would not be considered remuneration under this section if the waiver is not offered as part of

any advertisement or solicitation, the person does not routinely waive coinsurance or deductible amounts, and the person either waives the coinsurance and deductible amounts because the individual is in financial need, or fails to collect the amounts after reasonable collection efforts, or provides for a permissible waiver under regulations issued by the Secretary. In addition, the term remuneration would not include differentials in coinsurance and deductible amounts as part of a benefit plan design if the differentials have been disclosed in writing to all beneficiaries, third party payers, and providers, and if the differentials meet the standards defined in the Secretary's regulations. Remuneration would also not include incentives given to individuals to promote the delivery of preventive care under the Secretary's regulations.

Effective date

The amendments made by this section shall take effect on January 1, 1997.

Sec. 232. Clarification of level of intent required for imposition of civil monetary penalties

Under current law, civil money penalties may be imposed for seeking reimbursement under the Medicare and Medicaid programs for items or services not provided or for services provided by someone who is not a licensed physician, whose license was obtained through misrepresentation, or who misrepresented his or her qualification as a specialist, or where the claim is otherwise fraudulent. Civil penalties may also be sought for presenting a claim due for payments which are in violation of: (1) contracts limiting payment due to assignment of a patient; (2) agreements with State agencies limiting permitted charges; (3) agreement with participating physicians or supplier; and (4) agreements with providers of service. Civil penalties may also be sought against persons who provide false or misleading information that could reasonably be expected to influence a decision to discharge a person from a hospital. A person is subject to these provisions if they presented a claim and he or she "knows or should have known" that the claim fell into one of the categories listed above.

Section 232 adds a requirement, similar to the False Claims Act, that a person is subject to this provision when the person "knowingly" presents a claim that the person "knows or should know" fell into one of the prohibited categories. Thus, an assessment under this provision would only be made where a person had actual knowledge that he or she had submitted a claim or had provided false or misleading information, and where the person had actual knowledge of the fraudulent nature of the claim, acted in deliberate ignorance, or acted in reckless disregard. The requirement that a person "knowingly" presents a claim or "knowingly" makes a false or misleading statement which influences discharge would prevent charging persons who inadvertently perform these acts.

Sec. 233. Penalty for false certification for Home Health Services

In general

This section would add an additional civil monetary penalty of not more than three times the amount of the payments, or $5,000, whichever is greater, for a physician who certifies that an individual meets all of Medicare's requirements to receive home health care while knowing that the individual does not meet all such requirements.

Effective date

The amendment by this section would apply to certifications made on or after the date of enactment of this Act.

Subtitle E—Revisions to Criminal Law

Sec. 241. Definition of Federal health care offense

Federal health care offense is defined to mean a violation of, or a criminal conspiracy to violate section 669, 1035, or 1347 of Title 18, U.S. Code or section 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of this title.

Sec 242. Health care fraud

Depending on the facts of a particular case, under current law, criminal penalties may be imposed on persons engaged in health care fraud under Federal mail and wire fraud statutes, the False Claims Act, false statement statutes, money laundering statutes, racketeering, and other related laws.

Section 242 provides that criminal penalties would be imposed for knowingly and willfully executing a scheme, or artifice, or attempting to execute a scheme or artifice to defraud any health care program in connection with the payment or delivery of health care benefits, items or services. Penalties may also be imposed for obtaining money or property owned or under the custody or control of a health care program through false or fraudulent pretenses, representations, or promises. Persons who violate the above provisions may be subjected to up to ten years in prison or applicable fines or both. If the violation results in serious bodily injury, the person may be imprisoned for any term of years. An amount equal to the criminal fines imposed by this section shall be deposited in the Federal Hospital Insurance Trust Fund.

The term health care benefit program would mean any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract.

Sec. 243. Theft or embezzlement

Criminal penalties would be imposed for willfully embezzling, stealing, converting, or misapplying any of the moneys, funds, securities, premiums, credits, property, or other assets of a Federal health care program. A person convicted under this provision will be subject to a fine under title 18 of the United States Code, or im-

prisoned not more than 10 years, or both. If the value of property does not exceed $100, the defendant shall be fined or imprisoned not more than one year, or both.

Sec. 244. False statements

The Federal false statements provision at 18 U.S.C. § 1001 generally prohibits false statements with regard to any matter within the jurisdiction of a Federal department or agency.

Section 244 provides that criminal penalties would be imposed for knowingly and willfully falsifying, concealing, or covering up by any trick, scheme, or device a material fact, or making false, fictitious, or fraudulent statements or representation, or making or using any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry in any matter concerning a Federal health care program. A person convicted under this provision may be punished by the imposition of a fine or imprisoned not more than 5 years, or both.

Sec. 245. Obstruction of criminal investigations of health care offenses

Under current law, criminal penalties are imposed for obstructing, delaying or preventing the communication of information to law enforcement officials regarding the violation of criminal statutes by using bribery, intimidation, threats, corrupt persuasion, or harassment.

Section 245 provides that criminal penalties would be imposed for willfully preventing, obstructing, misleading, delaying or attempting to prevent, obstruct, mislead or delay the communication of information or records relating to a Federal health care offense to a criminal investigator. A person convicted under this provision may be punished by the imposition of fines under title 18 of the United States Code or by imprisonment of not more than 5 years, or both. Criminal investigator would mean any individual duly authorized by a department, agency, or armed force of the United States to conduct or engage investigations for prosecution for violations of health care offenses.

Sec. 246. Laundering of monetary instruments

The current Federal money laundering provision is found at 18 U.S.C. § 1956(c)(7), but does not include money laundering as related to health care fraud.

Section 246 provides that an act or activity constituting a Federal health care offense would be considered a "specified unlawful activity" for purposes of the prohibition on money laundering, so that any person who engages in money laundering in connection with a Federal health care offense would be subject to existing criminal penalties.

Sec. 247. Injunctive relief relating to Federal health care offenses

Depending on the facts of a particular case, under current law, injunctive relief may be imposed on persons who are committing or about to commit health care fraud under Federal racketeering statutes and other related laws.

Under Section 247, if a person is committing or about to commit a Federal health care offense, the Attorney General of the United States may commence a civil action in any Federal court to enjoin such a violation. If a person is alienating or disposing of property or intends to alienate or dispose of property obtained as a result of a Federal health care offense, the Attorney General may seek to enjoin such alienation or disposition, or may seek a restraining order to prohibit the person from withdrawing, transferring, removing, dissipating or disposing of any such property or property of equivalent value and appoint a temporary receiver to administer such restraining order.

Sec. 248. Authorized investigative demand procedures

Section 248 would provide procedures for the Attorney General to make investigative demands in cases regarding health care fraud. Under this section, the Attorney General could issue a summons for records and/or a witness to authenticate the records. Administrative summons are authorized for investigations of any scheme to defraud any health care benefit program in connection with the delivery of or payment for health care; or to fraudulently obtain money or property of a health plan or person in connection with the delivery of or payment for health care. This section would provide for service of a subpoena and enforcement of a subpoena in all United States courts, as well as a grant of immunity to persons responding to a subpoena from civil liability for disclosure of such information.

The section would also provide that health information about an individual that is disclosed under this section may not be used in, or disclosed to any person for use in, any administrative, civil, or criminal action or investigation directed against the individual who is the subject of the information unless the action or investigation arises out of, and is directly related to, receipt of health care or payment for health care or action involving a fraudulent claim related to health; or if good cause is shown.

Sec. 249. Forfeitures for Federal health care offenses

Depending on the facts of a particular case, under current law, criminal forfeiture may be imposed on persons convicted under Federal money laundering statutes, racketeering statutes, and other related laws.

Section 249 provides that a court imposing a sentence on a person convicted of a Federal health care offense would order the person to forfeit all real or personal property that is derived, directly or indirectly, from proceeds traceable to the commission of the offense. After payment of the costs of asset forfeiture have been made, the Secretary of the Treasury would deposit into the Federal Hospital Insurance Trust Fund an amount equal to the net amount realized from the forfeiture of property by reason of a Federal health care offense.

Subtitle F—Administrative Simplification

Section 251. Purpose

Section 251 provides the purpose of the subtitle is to improve the Medicare and Medicaid programs and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information.

Section 252. Administrative simplification

Section 252 amends title XI of the Social Security Act by adding a new "Part C—Administrative Simplification" and the following new sections.

New section 1171 would provide definitions for the part including the following: clearinghouse, code set, health care provider, health information, health plan, individually identifiable health information, standard, and standard setting organization. A clearinghouse would be a public or private entity that processes or facilitates the processing of nonstandard data elements of health information into standard data elements, or provides the means by which persons may meet the requirements of this part. A health plan would include Medicare, Medicaid, a Medicare supplemental policy, supplemental liability insurance, general liability insurance, worker's compensation or similar insurance, automobile or automobile medical-payment insurance, a long-term care policy, a hospital or fixed indemnity income-protection policy, and employee welfare benefit plan provided for 50 or more participants, an employee welfare benefit plan provided for 2 or more employers, the health care program for active military personnel, the veterans health care program, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the Indian Health Service program, the Federal Employees Health Benefits Plan, and such other plan or arrangement as the Secretary determines is a health plan.

New section 1172 would require that any standard adopted applies to the following persons: (1) a health plan, (2) a clearinghouse, or (3) a health care provider, but only to the extent that the provider was conducting transactions referred to in the bill. The bill would require that any standard adopted must reduce the administrative cost of providing and paying for health care. The standard setting organization would be required to develop or modify any standard adopted. The Secretary could adopt a standard that was different from any standard developed or modified by such organization if the different standard was promulgated in accordance with rulemaking procedures and would substantially reduce administrative costs to providers and plans compared to the alternatives. The Secretary would be required to establish specifications for implementing each of the standards adopted. The standards adopted would be prohibited from requiring disclosure of trade secrets or confidential commercial information by a participant in the health information network. In complying with the requirements of this part, the Secretary would be required to rely on the recommendations of the Health Information Advisory Committee established by the bill, and consult with appropriate Federal and State agencies

and private organizations. This section shall apply to a modification to a standard (including an addition to a standard) adopted under section 1174(b) in the same manner as it applies to an initial standard adopted under section 1174(a).

New section 1173 would require the Secretary to adopt appropriate standards for financial and administrative transactions and data elements exchanged electronically that are consistent with the goals of improving the operation of the health care system and reducing administrative costs. Financial and administrative transactions would include claims, claims attachments, enrollment and disenrollment, eligibility, health care payment and remittance advice, premium payments, first report of injury, claims status, and referral certification and authorization. Standards adopted by the Secretary would be required to accommodate the needs of different types of health care providers. While requiring standardization of data transmitted electronically among the persons governed by this part, the provisions of this part would not impose any requirement for information collecting or reporting.

The Secretary would be required to adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system. The Secretary would be required to adopt standards that select code sets for appropriate data elements or establish such code sets, and establish efficient and low-cost procedures for the distribution of code sets and modifications.

The Secretary would be required to establish security standards that (1) take into account the technical capabilities of record systems to maintain health information, the costs of security measures, the need for training persons with access to health information, the value of audit trails in computerized record systems used, and the needs and capabilities of small health care providers and rural health care providers; and (2) ensure that a clearinghouse, if it is part of a larger organization, has policies and security procedures which isolate the activities of such service to prevent unauthorized access to such information by such larger organization. Each person who maintains or transmits health information or data elements of health information would be required to maintain reasonable and appropriate administrative, technical and physical safeguards to (1) ensure the integrity and confidentiality of the information, (2) protect against any reasonably anticipated threats or hazards to the security or integrity of the information and unauthorized uses or disclosures of the information, and (3) otherwise ensure compliance with these requirements by the officers and employees of such person.

The Secretary would be required to establish standards and modifications to such standards regarding the privacy of individually identifiable health information that is in the health information network. Such standards would be required to include at least (1) the rights of an individual who is subject to such information, (2) the procedures to be established for the exercise of such rights, and (3) the uses and disclosures of such information that are authorized or required. The Secretary, in coordination with the Secretary of Commerce, would be required to adopt standards specifying procedures for the electronic transmission and authentication of

signatures, compliance with which would be deemed to satisfy Federal and State statutory requirements for written signatures with respect to the transactions specified by the bill. This part would not be construed to prohibit the payment of health care services or health plan premiums by debit, credit, payment card or numbers, or other electronic means. The Secretary would be required to adopt standards for transferring among health plans appropriate standard data elements needed for the coordination of benefits, the sequential processing of claims, and other data elements for individuals who have more than one health plan.

New section 1174 would require the Secretary to adopt standards relating to the transactions, data elements of health information, security and privacy by not later than 18 months after the date of enactment of the part, except that standards relating to claims attachments would be required to be adopted not later than 30 months after enactment. The Secretary would be required to review the adopted standards and adopt modifications to the standards (including additions to the standards) as appropriate, but not more frequently than once every 6 months, except during the first 12-month period after the standards are adopted unless the Secretary determines that a modification is necessary in order to permit compliance with the standards. The Secretary would also be required to ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets.

New section 1175 would establish that if a person desires to conduct a financial or administrative transaction with a health plan as a standard transaction, (1) the health plan may not refuse to conduct such transaction as a standard transaction, (2) the health plan may not delay such transaction, or otherwise adversely affect, or attempt to adversely affect, the person or the transaction on the grounds that the transaction is a standard transaction, and (3) the information transmitted and received in connection with the transaction would be required to be in a form of standard data elements for health information. Health plans could satisfy the transmission of information by directly transmitting standard data elements of health information, or submitting nonstandard data elements to a clearinghouse for processing into standard data elements and transmission. Not later than 24 months after the date on which standard or implementation specification was adopted or established under this part, each person to which the standard applied would be required to comply with the standard or specification. Small health plans, determined by the Secretary, would be required to comply not later than 36 months after standards were adopted. If the Secretary modified a standard or implementation specification, each person to whom it applied would be required to comply with the modified standard at such time as the Secretary determines appropriate, but no earlier than 180 days after such modification was adopted.

New section 1176 would require the Secretary to impose on any person who violates a provision under the bill a penalty of not more than $100 for each such violation of a specific standard or requirement, except that the total amount imposed on the person for all such violations during a calendar year would not exceed $25,000. A penalty would not be imposed if it was established that the per-

son liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person violated the provision. A penalty would not be imposed if (1) the failure to comply was due to reasonable cause and not willful neglect, and (2) the failure to comply was corrected during the 30-day period beginning on the first date the person liable for the penalty knew, or would have known, that the failure to comply occurred. The Secretary would be permitted to extend the 30-day period when appropriate, and could provide technical assistance to the person that failed to comply because they were unable to comply. In cases of a failure to comply due to reasonable cause and not to willful neglect, any penalty that was not entirely waived, could be waived to the extent that the payment of such penalty would be excessive relative to the compliance failure involved.

New section 1177 would define the offense of wrongful disclosure of individually identifiable health information as instances when a person who knowingly and in violation of this part (1) uses or causes to be used a unique health identifier; (2) obtains individually identifiable health information relating to an individual; or (3) discloses individually identifiable health information to another individual. A person committing such an offense would be required to (1) be fined not more than $50,000, imprisoned not more than 1 year, or both; (2) if the offense was committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both; and (3) if the offense was committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, fined not more than $250,000, imprisoned not more than 10 years, or both.

New section 1178 would require that a provision, requirement, or standard provided by the bill supersede any contrary provision of State law, including a provision of State law that required medical or health plan records (including billing information) to be maintained or transmitted in written rather that electronic form. A provision under the bill would not supersede a contrary provision of State law if the provision of State law (1) was more stringent than the requirements of the bill with respect to privacy or individually identifiable health information, or (2) was a provision the Secretary determined was necessary to prevent fraud and abuse, to address controlled substances, or for other purposes. Nothing in this section would be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth or death, public health surveillance, or public health investigation or intervention.

New section 1179 would provide for the establishment of a committee known as the Health Information Advisory Committee, consisting of 15 members. The committee would be required to (1) provide assistance to the Secretary with complying with the requirements of the bill; (2) study the issues related to the adoption of uniform data standards for patient medical record information and electronic exchange of such information; (3) report to the Secretary not later that 4 years after enactment of recommendations and legislative proposals for such standards and electronic exchange; and (4) be generally responsible for advising the Secretary and the Con-

gress on the status of the future of the health information network. The Committee would be required, not later than 1 year after enactment, to report to Congress on (1) the extent to which persons required to comply with this part are cooperating in implementing the standards; (2) the extent to which entities were meeting the privacy and security standards, and the types of penalties assessed for noncompliance; (3) whether the Federal and State governments were receiving information of sufficient quality to meet their responsibilities; (4) any problems that exist with implementation of the network; and (5) the extent to which timetables established by under this part of the bill were being met.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

SECTION 4980B OF THE INTERNAL REVENUE CODE OF 1986

* * * * * * *

SEC. 4980B. FAILURE TO SATISFY CONTINUATION COVERAGE REQUIREMENTS OF GROUP HEALTH PLANS.

(a) GENERAL RULE.—There is hereby imposed a tax on the failure of a group health plan to meet [the requirements of subsection (f) with respect to any qualified beneficiary.] *the requirements of—*

(1) subsection (f) with respect to any qualified beneficiary, or

(2) subject to subsection (h)—

(A) section 101 or 102 of the Health Coverage Availability and Affordability Act of 1996 with respect to any individual covered under the group health plan, or

(B) section 103 of such Act with respect to any individual.

* * * * * * *

(f) CONTINUATION COVERAGE REQUIREMENTS OF GROUP HEALTH PLANS.—

(1) * * *

* * * * * * *

(6) NOTICE REQUIREMENT.—In accordance with regulations prescribed by the secretary—

(A) The group health plan shall provide, at the time of commencement of coverage under the plan, written notice to each covered employee and spouse of the employee (if any) of the rights provided under this subsection *and subtitle A of title I of the Health Coverage Availability and Affordability Act of 1996.*

* * * * * * *

(h) SPECIAL RULES.—For purposes of applying this section in the case of requirements described in subsection (a)(2) relating to sec-

tion 101, section 102, or section 103 of the Health Coverage Availability and Affordability Act of 1996—

(1) DEFERRAL TO STATE REGULATIONS.—No tax shall be imposed by this section on any failure to meet the requirements of such section by any entity which offers health insurance coverage and which is an insurer or health maintenance organization (as defined in section 191(c) of the Health Coverage Availability and Affordability Act of 1996) regulated by a State if the Secretary of Health and Human Services has made the determination described in section 104(c)(2) of such Act with respect to such State, section, and entity.

(2) LIMITATION FOR INSURED PLANS.—In the case of a group health plan of a small employer (as defined in section 191 of the Health Coverage Availability and Affordability Act of 1996) that provides health care benefits solely through a contract with an insurer or health maintenance organization (as defined in such section), no tax shall be imposed by this section upon the employer on a failure to meet such requirements if the failure is solely because of the product offered by the insurer or organization under such contract.

(3) LIMITATION ON IMPOSITION OF TAX.—In no case shall a tax be imposed by this section for a failure to meet such a requirement if a sanction has been imposed—

(A) by the Secretary of Labor under part 5 of subtitle A of title I of the Employee Retirement Income Security Act of 1974 with respect to such failure, or

(B) by the Secretary of Health and Human Services under section 109 of the Health Coverage Availability and Affordability Act of 1996 with respect to such failure.

* * * * * * *

SOCIAL SECURITY ACT

* * * * * * *

DEFINITION OF WAGES

SEC. 209. (a) For the purposes of this title, the term "wages" means remuneration paid prior to 1951 which was wages for the purposes of this title under the law applicable to the payment of such remuneration, and remuneration paid after 1950 for employment, including the cash value of all remuneration (including benefits) paid in any medium other than cash; except that, in the case of remuneration paid after 1950, such term shall not include—

(1) * * *

* * * * * * *

(17) Any benefit provided to or on behalf of an employee if at the time such benefit is provided it is reasonable to believe that the employee will be able to exclude such benefit from income under section 74(c), 117, or 132 of the Internal Revenue Code of 1986; **[**or**]**

(18) Remuneration consisting of income excluded from taxation under section 7873 of the Internal Revenue Code of 1986

(relating to income derived by Indians from exercise of fishing rights) [.] *or*

(19) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b) of the Internal Revenue Code of 1986.

* * * * * * *

[TITLE XI—GENERAL PROVISIONS AND PEER REVIEW]

TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION

PART A—GENERAL PROVISIONS

EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS

SEC. 1128. (a) MANDATORY EXCLUSION.—The Secretary shall exclude the following individuals and entities from participation in any program under title XVIII and shall direct that the following individuals and entities be excluded from participation in any State health care program (as defined in subsection (h)):

(1) * * *

* * * * * * *

(3) FELONY CONVICTION RELATING TO HEALTH CARE FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.

(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

(b) PERMISSIVE EXCLUSION.—The Secretary may exclude the following individuals and entities from participation in any program under title XVIII and may direct that the following individuals and entities be excluded from participation in any State health care program:

[(1) CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a program operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense relating to fraud,

theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.]

(1) CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, under Federal or State law—

(A) of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct—

(i) in connection with the delivery of a health care item or service, or

(ii) with respect to any act or omission in a health care program (other than those specifically described in subsection (a)(1)) operated by or financed in whole or in part by any Federal, State, or local government agency; or

(B) of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency.

* * * * * * *

(3) [CONVICTION] *MISDEMEANOR CONVICTION* RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted, under Federal or State law, of a [criminal offense] *criminal offense consisting of a misdemeanor* relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

* * * * * * *

(15) INDIVIDUALS CONTROLLING A SANCTIONED ENTITY.—(A) Any individual—

(i) who has a direct or indirect ownership or control interest in a sanctioned entity and who knows or should know (as defined in section 1128A(i)(6)) of the action constituting the basis for the conviction or exclusion described in subparagraph (B); or

(ii) who is an officer or managing employee (as defined in section 1126(b)) of such an entity.

(B) For purposes of subparagraph (A), the term "sanctioned entity" means an entity—

(i) that has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection; or

(ii) that has been excluded from participation under a program under title XVIII or under a State health care program.

(c) NOTICE, EFFECTIVE DATE, AND PERIOD OF EXCLUSION.—(1) * * *

* * * * * * *

(3)(A) * * *

* * * * * * *

(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall not be less than 1 year.

* * * * * * *

CIVIL MONETARY PENALTIES

SEC. 1128A. (a) Any person (including an organization, agency, or other entity, but excluding a beneficiary, as defined in subsection (i)(5)) that—

(1) *knowingly* presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1)), a claim (as defined in subsection (i)(2)) that the Secretary determines—

(A) is for a medical or other item or service that the person knows or should know was not provided as [claimed,] *claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided,*

* * * * * * *

(C) is presented for a physician's service (or an item or service incident to a physician's service) by a person who knows or should know that the individual who furnished (or supervised the furnishing of) the service—

(i) was not licensed as a physician,

(ii) was licensed as a physician, but such license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing), or

(iii) represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board when the individual was not so certified, [or]

(D) is for a medical or other item or service furnished during a period in which the person was excluded from the program under which the claim was made pursuant to a determination by the Secretary under this section or under section 1128, 1156, 1160(b) (as in effect on September 2,

1982), 1862(d) (as in effect on the date of the enactment of the Medicare and Medicaid Patient and Program Protection Act of 1987), or 1866(b) or as a result of the application of the provisions of section 1842(j)(2)[; or], *or*

(E) is for a medical or other item or service that a person knows or should know is not medically necessary; or

(2) *knowingly* presents or causes to be presented to any person a request for payment which is in violation of the terms of (A) an assignment under section 1842(b)(3)(B)(ii), or (B) an agreement with a State agency (or other requirement of a State plan under title XIX) not to charge a person for an item or service in excess of the amount permitted to be charged, or (C) an agreement to be a participating physician or supplier under section 1842(h)(1), or (D) an agreement pursuant to section 1866(a)(1)(G)[, or];

(3) [gives] *knowingly gives or causes to be given* to any person, with respect to coverage under title XVIII of inpatient hospital services subject to the provisions of section 1886, information that he knows or should know is false or misleading, and that could reasonably be expected to influence the decision when to discharge such person or another individual from the hospital[;];

(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII or a State health care program in accordance with this subsection or under section 1128 and who, at the time of a violation of this subsection—

(A) retains a direct or indirect ownership or control interest in an entity that is participating in a program under title XVIII or a State health care program, and who knows or should know of the action constituting the basis for the exclusion; or

(B) is an officer or managing employee (as defined in section 1126(b)) of such an entity; or

(5) offers to or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program (as so defined);

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than [$2,000] *$10,000* for each item or service (or, in cases under paragraph (3), $15,000 for each individual with respect to whom false or misleading information was given*; in cases under paragraph (4), $10,000 for each day the prohibited relationship occurs*). In addition, such a person shall be subject to an assessment of not more than [twice the amount] *3 times the amount* claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim. In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the [programs under title XVIII] *Federal*

health care programs (as defined in section 1128B(f)(1)) and to direct the appropriate State agency to exclude the person from participation in any State health care program.

(b)(1) * * *

* * * * * * *

(3)(A) Any physician who executes a document described in subparagraph (B) with respect to an individual knowing that all of the requirements referred to in such subparagraph are not met with respect to the individual shall be subject to a civil monetary penalty of not more than the greater of—

(i) $5,000, or

(ii) three times the amount of the payments under title XVIII for home health services which are made pursuant to such certification.

(B) A document described in this subparagraph is any document that certifies, for purposes of title XVIII, that an individual meets the requirements of section 1814(a)(2)(C) or 1835(a)(2)(A) in the case of home health services furnished to the individual.

* * * * * * *

(f) Civil money penalties and assessments imposed under this section may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in United States district court for the district where the claim was presented, or where the claimant resides, as determined by the Secretary. Amounts recovered under this section shall be paid to the Secretary and disposed of as follows:

(1) * * *

* * * * * * *

(3) With respect to amounts recovered arising out of a claim under a Federal health care program (as defined in section 1128B(f)), the portion of such amounts as is determined to have been paid by the program shall be repaid to the program, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by the Health Coverage Availability and Affordability Act of 1996 (as estimated by the Secretary) shall be deposited into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C).

[(3)**]** *(4)* The remainder of the amounts recovered shall be deposited as miscellaneous receipts of the Treasury of the United States. The amount of such penalty or assessment, when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States or a State agency to the person against whom the penalty or assessment has been assessed.

* * * * * * *

(i) For the purposes of this section:

(1) The term ''State agency'' means the agency established or designated to administer or supervise the administration of the State plan under title XIX of this Act or designated to administer the State's program under title V or title XX of this Act.

(2) The term "claim" means an application for payments for items and services under [title V, XVIII, XIX, or XX of this Act] *a Federal health care program (as defined in section 1128B(f))*.

* * * * * * *

(4) The term "agency of the United States" includes any contractor acting as a fiscal intermediary, carrier, or fiscal agent of any other claims processing agent for [a health insurance or medical services program under title XVIII or XIX of this Act] *a Federal health care program (as so defined)*.

(5) The term "beneficiary" means an individual who is eligible to receive items or services for which payment may be made under [title V, XVIII, XIX, or XX] *a Federal health care program (as so defined)* but does not include a provider, supplier, or practitioner.

(6) The term "remuneration" includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term "remuneration" does not incude—

(A) the waiver of coinsurance and deductible amounts by a person if—

(i) the waiver is not offered as part of any advertisement or solicitation;

(ii) the person does not routinely waive coinsurance or deductible amounts; and

(iii) the person—

(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need;

(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or

(III) provides for any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary;

(B) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all beneficiaries, third party payers, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary not later than 180 days after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996; or

(C) incentives given to individuals to promote the delivery of preventive care as determined by the Secretary in regulations so promulgated.

(7) The term "should know" means that a person, with respect to information—

(A) acts in deliberate ignorance of the truth or falsity of the information; or

(B) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

* * * * * * *

(m)(1) For purposes of this section, with respect to a Federal health care program not contained in this Act, references to the Secretary in this section shall be deemed to be references to the Secretary or Administrator of the department or agency with jurisdiction over such program and references to the Inspector General of the Department of Health and Human Services in this section shall be deemed to be references to the Inspector General of the applicable department or agency.

(2)(A) The Secretary and Administrator of the departments and agencies referred to in paragraph (1) may include in any action pursuant to this section, claims within the jurisdiction of other Federal departments or agencies as long as the following conditions are satisfied:

(i) The case involves primarily claims submitted to the Federal health care programs of the department or agency initiating the action.

(ii) The Secretary or Administrator of the department or agency initiating the action gives notice and an opportunity to participate in the investigation to the Inspector General of the department or agency with primary jurisdiction over the Federal health care programs to which the claims were submitted.

(B) If the conditions specified in subparagraph (A) are fulfilled, the Inspector General of the department or agency initiating the action is authorized to exercise all powers granted under the Inspector General Act of 1978 with respect to the claims submitted to the other departments or agencies to the same manner and extent as provided in that Act with respect to claims submitted to such departments or agencies.

CRIMINAL PENALTIES FOR ACTS INVOLVING [MEDICARE OR STATE HEALTH CARE PROGRAMS] *FEDERAL HEALTH CARE PROGRAMS*

SEC. 1128B. (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under [a program under title XVIII or a State health care program (as defined in section 1128(h))], *a Federal health care program,*

* * * * * * *

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person, [or]

(5) presents or causes to be presented a claim for a physician's service for which payment may be made under [a program under title XVIII or a State health care program] *a Federal health care program* and knowns that the individual who furnished the service was not licensed as a physician, *or*

(6) knowingly and willfully disposes of assets (including by any transfer in trust) in order for an individual to become eligible for medical assistance under a State plan under title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c),

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under the program, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under [a State plan approved under title XIX] *a Federal health care program* is convicted of an offense under the preceding provisions of this subsection, [the State may at its option (notwithstanding any other provision of that title or of such plan)] *the administrator of such program may at its option (notwithstanding any other provision of such program)* limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under title XVIII or a State health care program, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under [title XVIII or a State health care program] *a Federal health care program,*

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under [title XVIII or a State health care program] *a Federal health care program,* or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or

item for which payment may be made in whole or in part under [title XVIII or a State health care program] *a Federal health care program*,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to—

(A) a discount or other reduction in price obtained by a provider of services or other entity under [title XVIII or a State health care program] if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under [title XVIII or a State health care program] *a Federal health care program*;

* * * * * * *

(C) any amount paid by a vendor og goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under [title XVIII or a State health care program] *a Federal health care program* if—

(i) * * *

* * * * * * *

(D) a waiver of any coinsurance under part B of title XVIII by a Federally qualified health care center with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act; [and]

(E) any payment practice specified by the Secretary in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987[.] *; and*

(F) any remuneration between an organization and an individual or entity providing items or services, or a combination thereof, pursuant to a written agreement between the organization and the individual or entity if the organization is an eligible organization under section 1876 or if the written agreement places the individual or entity at substantial financial risk for the cost or utilization of the items or services, or a combination thereof, which the individual or entity is obligated to provide, whether through a withhold, capitation, incentive pool, per diem payment, or any other similar risk arrangement which places the individual or entity at substantial financial risk.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution, facility, or entity in order that such institution, facility, or entity may qualify (either upon initial certification or upon recertification) as a hospital, rural primary care hospital, skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, or other entity (including an eligible organization under section 1876(b)) for which certification is required under title XVIII or a State health care program *(as defined in section 1128(h))*, or with respect to information required to be provided under section 1124A, shall be guilty of a felony and

upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than 5 years, or both.

* * * * * * *

(f) For purposes of this section, the term "Federal health care program" means—

(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5, United States Code); or

(2) any State health care program, as defined in section 1128(h);

FRAUD AND ABUSE CONTROL PROGRAM

SEC. 1128C. (a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—Not later than January 1, 1997, the Secretary, acting through the Office of the Inspector General of the Department of Health and Human Services, and the Attorney General shall establish a program—

(A) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to health plans,

(B) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States,

(C) to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B and other statutes applicable to health care fraud and abuse,

(D) to provide for the modification and establishment of safe harbors and to issue advisory opinions and special fraud alerts pursuant to section 1128D, and

(E) to provide for the reporting and disclosure of certain final adverse actions against health care providers, suppliers, or practitioners pursuant to the data collection system established under section 1128E.

(2) COORDINATION WITH HEALTH PLANS.—In carrying out the program established under paragraph (1), the Secretary and the Attorney General shall consult with, and arrange for the sharing of data with representatives of health plans.

(3) GUIDELINES.—

(A) IN GENERAL.—The Secretary and the Attorney General shall issue guidelines to carry out the program under paragraph (1). The provisions of sections 553, 556, and 557 of title 5, United States Code, shall not apply in the issuance of such guidelines.

(B) INFORMATION GUIDELINES.—

(i) IN GENERAL.—Such guidelines shall include guidelines relating to the furnishing of information by health plans, providers, and others to enable the Secretary and the Attorney General to carry out the program (including coordination with health plans under paragraph (2)).

(ii) CONFIDENTIALITY.—Such guidelines shall include procedures to assure that such information is provided and utilized in a manner that appropriately protects the confidentiality of the information and the privacy of individuals receiving health care services and items.

(iii) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) (relating to limitation on liability) shall apply to a person providing information to the Secretary or the Attorney General in conjunction with their performance of duties under this section.

(4) ENSURING ACCESS TO DOCUMENTATION.—The Inspector General of the Department of Health and Human Services is authorized to exercise such authority described in paragraphs (3) through (9) of section 6 of the Inspector General Act of 1978 (5 U.S.C. App.) as necessary with respect to the activities under the fraud and abuse control program established under this subsection.

(5) AUTHORITY OF INSPECTOR GENERAL.—Nothing in this Act shall be construed to diminish the authority of any Inspector General, including such authority as provided in the Inspector General Act of 1978 (5 U.S.C. App.).

(b) ADDITIONAL USE OF FUNDS BY INSPECTOR GENERAL.—

(1) REIMBURSEMENTS FOR INVESTIGATIONS.—The Inspector General of the Department of Health and Human Services is authorized to receive and retain for current use reimbursement for the costs of conducting investigations and audits and for monitoring compliance plans when such costs are ordered by a court, voluntarily agreed to by the payor, or otherwise.

(2) CREDITING.—Funds received by the Inspector General under paragraph (1) as reimbursement for costs of conducting investigations shall be deposited to the credit of the appropriation from which initially paid, or to appropriations for similar purposes currently available at the time of deposit, and shall remain available for obligation for 1 year from the date of the deposit of such funds.

(c) HEALTH PLAN DEFINED.—For purposes of this section, the term "health plan" means a plan or program that provides health benefits, whether directly, through insurance, or otherwise, and includes—

(1) a policy of health insurance;

(2) a contract of a service benefit organization; and

(3) a membership agreement with a health maintenance organization or other prepaid health plan.

GUIDANCE REGARDING APPLICATION OF HEALTH CARE FRAUD AND ABUSE SANCTIONS

SEC. 1128D. (a) SOLICITATION AND PUBLICATION OF MODIFICATIONS TO EXISTING SAFE HARBORS AND NEW SAFE HARBORS.—

(1) IN GENERAL.—

(A) SOLICITATION OF PROPOSALS FOR SAFE HARBORS.—Not later than January 1, 1997, and not less than annually thereafter, the Secretary shall publish a notice in the Fed-

eral Register soliciting proposals, which will be accepted during a 60-day period, for—

(i) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987 (42 U.S.C. 1320a–7b note);

(ii) additional safe harbors specifying payment practices that shall not be treated as a criminal offense under section 1128B(b) and shall not serve as the basis for an exclusion under section 1128(b)(7);

(iii) advisory opinions to be issued pursuant to subsection (b); and

(iv) special fraud alerts to be issued pursuant to subsection (c).

(B) PUBLICATION OF PROPOSED MODIFICATIONS AND PROPOSED ADDITIONAL SAFE HARBORS.—After considering the proposals described in clauses (i) and (ii) of subparagraph (A), the Secretary, in consultation with the Attorney General, shall publish in the Federal Register proposed modifications to existing safe harbors and proposed additional safe harbors, if appropriate, with a 60-day comment period. After considering any public comments received during this period, the Secretary shall issue final rules modifying the existing safe harbors and establishing new safe harbors, as appropriate.

(C) REPORT.—The Inspector General of the Department of Health and Human Services (in this section referred to as the "Inspector General") shall, in an annual report to Congress or as part of the year-end semiannual report required by section 5 of the Inspector General Act of 1978 (5 U.S.C. App.), describe the proposals received under clauses (i) and (ii) of subparagraph (A) and explain which proposals were included in the publication described in subparagraph (B), which proposals were not included in that publication, and the reasons for the rejection of the proposals that were not included.

(2) CRITERIA FOR MODIFYING AND ESTABLISHING SAFE HARBORS.—In modifying and establishing safe harbors under paragraph (1)(B), the Secretary may consider the extent to which providing a safe harbor for the specified payment practice may result in any of the following:

(A) An increase or decrease in access to health care services.

(B) An increase or decrease in the quality of health care services.

(C) An increase or decrease in patient freedom of choice among health care providers.

(D) An increase or decrease in competition among health care providers.

(E) An increase or decrease in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

(F) An increase or decrease in the cost to Federal health care programs (as defined in section 1128B(f)).

(G) An increase or decrease in the potential overutilization of health care services.

(H) The existence or nonexistence of any potential financial benefit to a health care professional or provider which may vary based on their decisions of—

(i) whether to order a health care item or service; or

(ii) whether to arrange for a referral of health care items or services to a particular practitioner or provider.

(I) Any other factors the Secretary deems appropriate in the interest of preventing fraud and abuse in Federal health care programs (as so defined).

(b) ADVISORY OPINIONS.—

(1) ISSUANCE OF ADVISORY OPINIONS.—The Secretary shall issue written advisory opinions as provided in this subsection.

(2) MATTERS SUBJECT TO ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as to the following matters:

(A) What constitutes prohibited remuneration within the meaning of section 1128B(b).

(B) Whether an arrangement or proposed arrangement satisfies the criteria set forth in section 1128B(b)(3) for activities which do not result in prohibited remuneration.

(C) Whether an arrangement or proposed arrangement satisfies the criteria which the Secretary has established, or shall establish by regulation for activities which do not result in prohibited remuneration.

(D) What constitutes an inducement to reduce or limit services to individuals entitled to benefits under title XVIII or title XIX or title XXI within the meaning of section 1128B(b).

(E) Whether any activity or proposed activity constitutes grounds for the imposition of a sanction under section 1128, 1128A, or 1128B.

(3) MATTERS NOT SUBJECT TO ADVISORY OPINIONS.—Such advisory opinions shall not address the following matters:

(A) Whether the fair market value shall be, or was paid or received for any goods, services or property.

(B) Whether an individual is a bona fide employee within the requirements of section 3121(d)(2) of the Internal Revenue Code of 1986.

(4) EFFECT OF ADVISORY OPINIONS.—

(A) BINDING AS TO SECRETARY AND PARTIES INVOLVED.—Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

(B) FAILURE TO SEEK OPINION.—The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of sections 1128, 1128A, or 1128B.

(5) REGULATIONS.—

(A) IN GENERAL.—Not later than 180 days after the date of the enactment of this section, the Secretary shall issue regulations to carry out this section. Such regulations shall provide for—

(i) the procedure to be followed by a party applying for an advisory opinion;

(ii) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

(iii) the interval in which the Secretary shall respond;

(iv) the reasonable fee to be charged to the party requesting an advisory opinion; and

(v) the manner in which advisory opinions will be made available to the public.

(B) SPECIFIC CONTENTS.—Under the regulations promulgated pursuant to subparagraph (A)—

(i) the Secretary shall be required to respond to a party requesting an advisory opinion by not later than 30 days after the request is received; and

(ii) the fee charged to the party requesting an advisory opinion shall be equal to the costs incurred by the Secretary in responding to the request.

(c) SPECIAL FRAUD ALERTS.—

(1) IN GENERAL.—

(A) REQUEST FOR SPECIAL FRAUD ALERTS.—Any person may present, at any time, a request to the Inspector General for a notice which informs the public of practices which the Inspector General considers to be suspect or of particular concern under the medicare program or a State health care program, as defined in section 1128(h) (in this subsection referred to as a "special fraud alert").

(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—Upon receipt of a request described in subparagraph (A), the Inspector General shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Inspector General shall issue a special fraud alert in response to the request. All special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

(2) CRITERIA FOR SPECIAL FRAUD ALERTS.—In determining whether to issue a special fraud alert upon a request described in paragraph (1), the Inspector General may consider—

(A) whether and to what extent the practices that would be identified in the special fraud alert may result in any of the consequences described in subsection (a)(2); and

(B) the volume and frequency of the conduct that would be identified in the special fraud alert.

HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM

SEC. 1128E. (a) GENERAL PURPOSE.—Not later than January 1, 1997, the Secretary shall establish a national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (c).

(b) REPORTING OF INFORMATION.—

(1) IN GENERAL.—Each Government agency and health plan shall report any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner.

(2) INFORMATION TO BE REPORTED.—The information to be reported under paragraph (1) includes:

(A) The name and TIN (as defined in section 7701(a)(41) of the Internal Revenue Code of 1986) of any health care provider, supplier, or practitioner who is the subject of a final adverse action.

(B) The name (if known) of any health care entity with which a health care provider, supplier, or practitioner is affiliated or associated.

(C) The nature of the final adverse action and whether such action is on appeal.

(D) A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the Secretary determines by regulation is required for appropriate interpretation of information reported under this section.

(3) CONFIDENTIALITY.—In determining what information is required, the Secretary shall include procedures to assure that the privacy of individuals receiving health care services is appropriately protected.

(4) TIMING AND FORM OF REPORTING.—The information required to be reported under this subsection shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be required to be reported on a date specified by the Secretary.

(5) TO WHOM REPORTED.—The information required to be reported under this subsection shall be reported to the Secretary.

(c) DISCLOSURE AND CORRECTION OF INFORMATION.—

(1) DISCLOSURE.—With respect to the information about final adverse actions (not including settlements in which no findings of liability have been made) reported to the Secretary under this section respecting a health care provider, supplier, or practitioner, the Secretary shall, by regulation, provide for—

(A) disclosure of the information, upon request, to the health care provider, supplier, or licensed practitioner, and

(B) procedures in the case of disputed accuracy of the information.

(2) CORRECTIONS.—Each Government agency and health plan shall report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, in such form and manner that the Secretary prescribes by regulation.

(d) ACCESS TO REPORTED INFORMATION.—

(1) AVAILABILITY.—The information in this database shall be available to Federal and State government agencies and health plans pursuant to procedures that the Secretary shall provide by regulation.

(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information in this

database (other than with respect to requests by Federal agencies). The amount of such a fee shall be sufficient to recover the full costs of operating the database. Such fees shall be available to the Secretary or, in the Secretary's discretion to the agency designated under this section to cover such costs.

(e) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity, including the agency designated by the Secretary in subsection (b)(5) shall be held liable in any civil action with respect to any report made as required by this section, without knowledge of the falsity of the information contained in the report.

(f) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

(1) FINAL ADVERSE ACTION.—

(A) IN GENERAL.—The term "final adverse action" includes:

(i) Civil judgments against a health care provider, supplier, or practitioner in Federal or State court related to the delivery of a health care item or service.

(ii) Federal or State criminal convictions related to the delivery of a health care item or service.

(iii) Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including—

(I) formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation,

(II) any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or

(III) any other negative action or finding by such Federal or State agency that is publicly available information.

(iv) Exclusion from participation in Federal or State health care programs.

(v) Any other adjudicated actions or decisions that the Secretary shall establish by regulation.

(B) EXCEPTION.—The term does not include any action with respect to a malpractice claim.

(2) PRACTITIONER.—The terms "licensed health care practitioner", "licensed practitioner", and "practitioner" mean, with respect to a State, an individual who is licensed or otherwise authorized by the State to provide health care services (or any individual who, without authority holds himself or herself out to be so licensed or authorized).

(3) GOVERNMENT AGENCY.—The term "Government agency" shall include:

(A) The Department of Justice.

(B) The Department of Health and Human Services.

(C) Any other Federal agency that either administers or provides payment for the delivery of health care services,

including, but not limited to the Department of Defense and the Veterans' Administration.

(D) State law enforcement agencies.

(E) State medicaid fraud control units.

(F) Federal or State agencies responsible for the licensing and certification of health care providers and licensed health care practitioners.

(4) HEALTH PLAN.—The term "health plan" has the meaning given such term by section 1128C(c).

(5) DETERMINATION OF CONVICTION.—For purposes of paragraph (1), the existence of a conviction shall be determined under paragraph (4) of section 1128(i).

PART B—PEER REVIEW OF THE UTILIZATION AND QUALITY OF HEALTH CARE SERVICES

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OBLIGATIONS OF HEALTH CARE PRACTITIONERS AND PROVIDERS OF HEALTH CARE SERVICES, SANCTIONS AND PENALTIES; HEARINGS AND REVIEW

SEC. 1156. (a) * * *

(b)(1) If after reasonable notice and opportunity for discussion with the practitioner or person concerned, and, if appropriate, after the practitioner or person has been given a reasonable opportunity to enter into and complete a corrective action plan (which may include remedial education) agreed to by the organization, and has failed successfully to complete such plan, any organization having a contract with the Secretary under this part determines that such practitioner or person has—

(A) failed in a substantial number of cases substantially to comply with any obligation imposed on him under subsection (a), or

(B) grossly and flagrantly violated any such obligation in one or more instances,

such organization shall submit a report and recommendations to the Secretary. If the Secretary agrees with such determination, **[**and determines that such practitioner or person, in providing health care services over which such organization has review responsibility and for which payment (in whole or in part) may be made under this Act, has demonstrated an unwillingness or a lack of ability substantially to comply with such obligations,**]** the Secretary (in addition to any other sanction provided under law) may exclude (permanently or for such period as the Secretary **[**may prescribe**]** *may prescribe, except that such period may not be less than 1 year)* such practitioner or person from eligibility to provide services under this Act on a reimbursable basis. **[**In determining whether a practitioner or person has demonstrated an unwillingness or lack of ability substantially to comply with such obligations, the Secretary shall consider the practitioner's or person's willingness or lack of ability, during the period before the organization submits its report and recommendations, to enter into and successfully complete a corrective action plan. **[**If the Secretary fails to act upon the recommendations submitted to him by such organization

within 120 days after such submission, such practitioner or person shall be excluded from eligibility to provide services on a reimbursable basis until such time as the Secretary determines otherwise.

(2) A determination made by the Secretary under this subsection to exclude a practitioner or person shall be effective on the same date and in the same manner as an exclusion from participation under the programs under this Act becomes effective under section 1128(c), and [shall remain] *shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain* in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

(3) In lieu of the sanction authorized by paragraph (1), the Secretary may require that (as a condition to the continued eligibility of such practitioner or person to provide such health care services on a reimbursable basis) such practitioner or person pays to the United States, in case such acts or conduct involved the provision or ordering by such practitioner or person of health care services which were medically improper or unnecessary, an amount not in excess of [the actual or estimated cost] *up to $10,000 for each instance* of the medically improper of unnecessary services so provided. Such amount may be deducted from sums owing by the United States for any instrumentality thereof) to the practitioner or person from whom such amount is claimed.

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PART C—ADMINISTRATIVE SIMPLIFICATION

SEC. 1171. DEFINITIONS.

For purposes of this part:

(1) CLEARINGHOUSE.—The term "clearinghouse" means a public or private entity that—

(A) processes or facilitates the processing of nonstandard data elements of health information into standard data elements; or

(B) provides the means by which persons may meet the requirements of this part.

(2) CODE SET.—The term "code set" means any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

(3) HEALTH CARE PROVIDER.—The term "health care provider" includes a provider of services (as defined in section 1861(u)), a provider of medical or other health services (as defined in section 1861(s)), and any other person furnishing health care services or supplies.

(4) HEALTH INFORMATION.—The term "health information" means any information, whether oral or recorded in any form or medium that—

(A) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or clearinghouse; and

(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

(5) HEALTH PLAN.—The term "health plan" means a plan which provides, or pays the cost of, health benefits. Such term includes the following, or any combination thereof:

(A) Part A or part B of the medicare program under title XVIII.

(B) The medicaid program under title XIX.

(C) A medicare supplemental policy (as defined in section 1882(g)(1)).

(D) Coverage issued as a supplement to liability insurance.

(E) General liability insurance.

(F) Worker's compensation or similar insurance.

(G) Automobile or automobile medical-payment insurance.

(H) A long-term care policy, including a nursing home fixed indemnity policy (unless the Secretary determines that such a policy does not provide sufficiently comprehensive coverage of a benefit so that the policy should be treated as a health plan).

(I) A hospital or fixed indemnity income-protection policy.

(J) An employee welfare benefit plan, as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(1)), but only to the extent the plan is established or maintained for the purpose of providing health benefits and has 50 or more participants (as defined in section 3(7) of such Act).

(K) An employee welfare benefit plan or any other arrangement which is established or maintained for the purpose of offering or providing health benefits to the employees of 2 or more employers.

(L) The health care program for active military personnel under title 10, United States Code.

(M) The veterans health care program under chapter 17 of title 38, United States Code.

(N) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in section 1073(4) of title 10, United States Code.

(O) The Indian health service program under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

(P) The Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code.

(Q) Such other plan or arrangement as the Secretary determines is a health plan.

(6) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term "individually identifiable health information" means any information, including demographic information collected from an individual, that—

(A) is created or received by a health care provider, health plan, employer, or clearinghouse; and

(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and—

(i) identifies the individual; or

(ii) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

(7) STANDARD.—The term "standard", when used with reference to a data element of health information or a transaction referred to in section 1173(a)(1), means any such data element or transaction that meets each of the standards and implementation specifications adopted or established by the Secretary with respect to the data element or transaction under sections 1172 through 1174.

(8) STANDARD SETTING ORGANIZATION.—The term "standard setting organization" means a standard setting organization accredited by the American National Standards Institute, including the National Council for Prescription Drug Programs, that develops standards for information transactions, data elements, or any other standard that is necessary to, or will facilitate, the implementation of this part.

SEC. 1172. GENERAL REQUIREMENTS FOR ADOPTION OF STANDARDS.

(a) APPLICABILITY.—Any standard adopted under this part shall apply to the following persons:

(1) A health plan.

(2) A clearinghouse.

(3) A health care provider who transmits any health information in electronic form in connection with a transaction referred to in section 1173(a)(1).

(b) REDUCTION OF COSTS.—Any standard adopted under this part shall be consistent with the objective of reducing the administrative costs of providing and paying for health care.

(c) ROLE OF STANDARD SETTING ORGANIZATIONS.—

(1) IN GENERAL.—Except as provided in paragraph (2), any standard adopted under this part shall be developed or modified by a standard setting organization.

(2) SPECIAL RULES.—

(A) DIFFERENT STANDARDS.—The Secretary may adopt a standard that is different from any standard developed or modified by a standard setting organization, if—

(i) the different standard will substantially reduce administrative costs to health care providers and health plans compared to the alternatives; and

(ii) the standard is promulgated in accordance with the rulemaking procedures of subchapter III of chapter 5 of title 5, United States Code.

(B) NO STANDARD BY STANDARD SETTING ORGANIZATION.—If no standard setting organization has adopted or modified any standard relating to a standard that the Secretary is authorized or required to adopt under this part—

(i) paragraph (1) shall not apply; and

(ii) subsection (f) shall apply.

(d) IMPLEMENTATION SPECIFICATIONS.—The Secretary shall establish specifications for implementing each of the standards adopted under this part.

(e) PROTECTION OF TRADE SECRETS.—Except as otherwise required by law, a standard adopted under this part shall not require disclosure of trade secrets or confidential commercial information by a person required to comply with this part.

(f) ASSISTANCE TO THE SECRETARY.—In complying with the requirements of this part, the Secretary shall rely on the recommendations of the Health Information Advisory Committee established under section 1179 and shall consult with appropriate Federal and State agencies and private organizations. The Secretary shall publish in the Federal Register the recommendations of the Health Information Advisory Committee regarding the adoption of a standard under this part.

(g) APPLICATION TO MODIFICATIONS OF STANDARDS.—This section shall apply to a modification to a standard (including an addition to a standard) adopted under section 1174(b) in the same manner as it applies to an initial standard adopted under section 1174(a).

SEC. 1173. STANDARDS FOR INFORMATION TRANSACTIONS AND DATA ELEMENTS.

(a) STANDARDS TO ENABLE ELECTRONIC EXCHANGE.—

(1) IN GENERAL.—The Secretary shall adopt standards for transactions, and data elements for such transactions, to enable health information to be exchanged electronically, that are—

(A) appropriate for the financial and administrative transactions described in paragraph (2); and

(B) related to other financial and administrative transactions determined appropriate by the Secretary consistent with the goals of improving the operation of the health care system and reducing administrative costs.

(2) TRANSACTIONS.—The transactions referred to in paragraph (1)(A) are the following:

(A) Claims (including coordination of benefits) or equivalent encounter information.

(B) Claims attachments.

(C) Enrollment and disenrollment.

(D) Eligibility.

(E) Health care payment and remittance advice.

(F) Premium payments.

(G) First report of injury.

(H) Claims status.

(I) Referral certification and authorization.

(3) ACCOMMODATION OF SPECIFIC PROVIDERS.—The standards adopted by the Secretary under paragraph (1) shall accommodate the needs of different types of health care providers.

(b) UNIQUE HEALTH IDENTIFIERS.—

(1) IN GENERAL.—The Secretary shall adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system. In carrying out the preceding sentence for each health plan and health care provider, the Secretary shall take into account multiple uses for identifiers and mul-

tiple locations and specialty classifications for health care providers.

(2) USE OF IDENTIFIERS.—The standards adopted under paragraphs (1) shall specify the purposes for which a unique health identifier may be used.

(c) CODE SETS.—

(1) IN GENERAL.—The Secretary shall adopt standards that—

(A) select code sets for appropriate data elements for the transactions referred to in subsection (a)(1) from among the code sets that have been developed by private and public entities; or

(B) establish code sets for such data elements if no code sets for the data elements have been developed.

(2) DISTRIBUTION.—The Secretary shall establish efficient and low-cost procedures for distribution (including electronic distribution) of code sets and modifications made to such code sets under section 1174(b).

(d) SECURITY STANDARDS FOR HEALTH INFORMATION.—

(1) SECURITY STANDARDS.—The Secretary shall adopt security standards that—

(A) take into account—

(i) the technical capabilities of record systems used to maintain health information;

(ii) the costs of security measures;

(iii) the need for training persons who have access to health information;

(iv) the value of audit trails in computerized record systems; and

(v) the needs and capabilities of small health care providers and rural health care providers (as such providers are defined by the Secretary); and

(B) ensure that a clearinghouse, if it is part of a larger organization, has policies and security procedures which isolate the activities of the clearinghouse with respect to processing information in a manner that prevents unauthorized access to such information by such larger organization.

(2) SAFEGUARDS.—Each person described in section 1172(a) who maintains or transmits health information shall maintain reasonable and appropriate administrative, technical, and physical safeguards—

(A) to ensure the integrity and confidentiality of the information;

(B) to protect against any reasonably anticipated—

(i) threats or hazards to the security or integrity of the information; and

(ii) unauthorized uses or disclosures of the information; and

(C) otherwise to ensure compliance with this part by the officers and employees of such person.

(e) PRIVACY STANDARDS FOR HEALTH INFORMATION.—The Secretary shall adopt standards with respect to the privacy of individually identifiable health information. Such standards shall include standards concerning at least the following:

(1) The rights of an individual who is a subject of such information.

(2) The procedures to be established for the exercise of such rights.

(3) The uses and disclosures of such information that are authorized or required.

(f) ELECTRONIC SIGNATURE.—

(1) IN GENERAL.—The Secretary, in coordination with the Secretary of Commerce, shall adopt standards specifying procedures for the electronic transmission and authentication of signatures, compliance with which shall be deemed to satisfy Federal and State statutory requirements for written signatures with respect to the transactions referred to in subsection (a)(1).

(2) PAYMENTS FOR SERVICES AND PREMIUMS.—Nothing in this part shall be construed to prohibit payment for health care services or health plan premiums by debit, credit, payment card or numbers, or other electronic means.

(g) TRANSFER OF INFORMATION AMONG HEALTH PLANS.—The Secretary shall adopt standards for transferring among health plans appropriate standard data elements needed for the coordination of benefits, the sequential processing of claims, and other data elements for individuals who have more than one health plan.

SEC. 1174. TIMETABLES FOR ADOPTION OF STANDARDS.

(a) INITIAL STANDARDS.—The Secretary shall carry out section 1173 not later than 18 months after the date of the enactment of this part, except that standards relating to claims attachments shall be adopted not later than 30 months after such date.

(b) ADDITIONS AND MODIFICATIONS TO STANDARDS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall review the standards adopted under section 1173, and shall adopt modifications to the standards (including additions to the standards), as determined appropriate, but not more frequently than once every 6 months. Any addition or modification to a standard shall be completed in a manner which minimizes the disruption and cost of compliance.

(2) SPECIAL RULES.—

(A) FIRST 12-MONTH PERIOD.—Except with respect to additions and modifications to code sets under subparagraph (B), the Secretary may not adopt any modification to a standard adopted under this part during the 12-month period beginning on the date the standard is initially adopted, unless the Secretary determines that the modification is necessary in order to permit compliance with the standard.

(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

(i) IN GENERAL.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets.

(ii) ADDITIONAL RULES.—If a code set is modified under this subsection, the modified code set shall include instructions on how data elements of health information that were encoded prior to the modification may be converted or translated so as to preserve the informational value of the data elements that existed before the modification. Any modification to a code set

under this subsection shall be implemented in a manner that minimizes the disruption and cost of complying with such modification.

SEC. 1175. REQUIREMENTS.

(a) CONDUCT OF TRANSACTIONS BY PLANS.—

(1) IN GENERAL.—If a person desires to conduct a transaction referred to in section 1173(a)(1) with a health plan as a standard transaction—

(A) the health plan may not refuse to conduct such transaction as a standard transaction;

(B) the health plan may not delay such transaction, or otherwise adversely affect, or attempt to adversely affect, the person or the transaction on the ground that the transaction is a standard transaction; and

(C) the information transmitted and received in connection with the transaction shall be in the form of standard data elements of health information.

(2) SATISFACTION OF REQUIREMENTS.—A health plan may satisfy the requirements under paragraph (1) by—

(A) directly transmitting and receiving standard data elements of health information; or

(B) submitting nonstandard data elements to a clearinghouse for processing into standard data elements and transmission by the clearinghouse, and receiving standard data elements through the clearinghouse.

(3) TIMETABLE FOR COMPLIANCE.—Paragraph (1) shall not be construed to require a health plan to comply with any standard, implementation specification, or modification to a standard or specification adopted or established by the Secretary under sections 1172 through 1174 at any time prior to the date on which the plan is required to comply with the standard or specification under subsection (b).

(b) COMPLIANCE WITH STANDARDS.—

(1) INITIAL COMPLIANCE.—

(A) IN GENERAL.—Not later than 24 months after the date on which an initial standard or implementation specification is adopted or established under sections 1172 and 1173, each person to whom the standard or implementation specification applies shall comply with the standard or specification.

(B) SPECIAL RULE FOR SMALL HEALTH PLANS.—In the case of a small health plan, paragraph (1) shall be applied by substituting 36 months' for 24 months'. For purposes of this subsection, the Secretary shall determine the plans that qualify as small health plans.

(2) COMPLIANCE WITH MODIFIED STANDARDS.—If the Secretary adopts a modification to a standard or implementation specification under this part, each person to whom the standard or implementation specification applies shall comply with the modified standard or implementation specification at such time as the Secretary determines appropriate, taking into account the time needed to comply due to the nature and extent of the modification. The time determined appropriate under the preceding sentence may not be earlier than the last day of the 180-day pe-

riod beginning on the date such modification is adopted. The Secretary may extend the time for compliance for small health plans, if the Secretary determines that such extension is appropriate.

SEC. 1176. GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS AND STANDARDS.

(a) GENERAL PENALTY.—

(1) IN GENERAL.—Except as provided in subsection (b), the Secretary shall impose on any person who violates a provision of this part a penalty of not more than $100 for each such violation, except that the total amount imposed on the person for all violations of an identical requirement or prohibition during a calendar year may not exceed $25,000.

(2) PROCEDURES.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil money penalty under this subsection in the same manner as such provisions apply to the imposition of a penalty under such section 1128A.

(b) LIMITATIONS.—

(1) OFFENSES OTHERWISE PUNISHABLE.—A penalty may not be imposed under subsection (a) with respect to an act if the act constitutes an offense punishable under section 1177.

(2) NONCOMPLIANCE NOT DISCOVERED.—A penalty may not be imposed under subsection (a) with respect to a provision of this part if it is established to the satisfaction of the Secretary that the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person violated the provision.

(3) FAILURES DUE TO REASONABLE CAUSE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), a penalty may not be imposed under subsection (a) if—

(i) the failure to comply was due to reasonable cause and not to willful neglect; and

(ii) the failure to comply is corrected during the 30-day period beginning on the first date the person liable for the penalty knew, or by exercising reasonable diligence would have known, that the failure to comply occurred.

(B) EXTENSION OF PERIOD.—

(i) NO PENALTY.—The period referred to in subparagraph (A)(ii) may be extended as determined appropriate by the Secretary based on the nature and extent of the failure to comply.

(ii) ASSISTANCE.—If the Secretary determines that a person failed to comply because the person was unable to comply, the Secretary may provide technical assistance to the person during the period described in subparagraph (A)(ii). Such assistance shall be provided in any manner determined appropriate by the Secretary.

(4) REDUCTION.—In the case of a failure to comply which is due to reasonable cause and not to willful neglect, any penalty under subsection (a) that is not entirely waived under paragraph (3) may be waived to the extent that the payment of such

penalty would be excessive relative to the compliance failure involved.

SEC. 1177. WRONGFUL DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

(a) OFFENSE.—A person who knowingly and in violation of this part—

(1) uses or causes to be used a unique health identifier;

(2) obtains individually identifiable health information relating to an individual; or

(3) discloses individually identifiable health information to another person,

shall be punished as provided in subsection (b).

(b) PENALTIES.—A person described in subsection (a) shall—

(1) be fined not more than $50,000, imprisoned not more than 1 year, or both;

(2) if the offense is committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both; and

(3) if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, fined not more than $250,000, imprisoned not more than 10 years, or both.

SEC. 1178. EFFECT ON STATE LAW.

(a) GENERAL EFFECT.—

(1) GENERAL RULE.—Except as provided in paragraph (2), a provision or requirement under this part, or a standard or implementation specification adopted or established under sections 1172 through 1174, shall supersede any contrary provision of State law, including a provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form.

(2) EXCEPTIONS.—A provision or requirement under this part, or a standard or implementation specification adopted or established under sections 1172 through 1174, shall not supersede a contrary provision of State law, if the provision of State law—

(A) imposes requirements, standards, or implementation specifications that are more stringent than the requirements, standards, or implementation specifications under this part with respect to the privacy of individually identifiable health information; or

(B) is a provision the Secretary determines—

(i) is necessary to prevent fraud and abuse, or for other purposes; or

(ii) addresses controlled substances.

(b) PUBLIC HEALTH REPORTING.—Nothing in this part shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.

SEC. 1179. HEALTH INFORMATION ADVISORY COMMITTEE.

(a) ESTABLISHMENT.—There is established a committee to be known as the Health Information Advisory Committee (in this section referred to as the "committee").

(b) DUTIES.—The committee shall—

(1) provide assistance to the Secretary in complying with the requirements imposed on the Secretary under this part;

(2) study the issues related to the adoption of uniform data standards for patient medical record information and the electronic exchange of such information;

(3) report to the Secretary not later than 4 years after the date of the enactment of this part recommendations and legislative proposals for such standards and electronic exchange; and

(4) generally be responsible for advising the Secretary and the Congress on the status of the implementation of this part.

(c) MEMBERSHIP.—

(1) IN GENERAL.—The committee shall consist of 15 members of whom—

(A) 3 shall be appointed by the President;

(B) 6 shall be appointed by the Speaker of the House of Representatives after consultation with the minority leader of the House of Representatives; and

(C) 6 shall be appointed by the President pro tempore of the Senate after consultation with the minority leader of the Senate.

The appointments of the members shall be made not later than 60 days after the date of the enactment of this part. The President shall designate 1 member as the Chair.

(2) EXPERTISE.—The membership of the committee shall consist of individuals who are of recognized standing and distinction in the areas of information systems, information networking and integration, consumer health, health care financial management, or privacy, and who possess the demonstrated capacity to discharge the duties imposed on the committee.

(3) TERMS.—Each member of the committee shall be appointed for a term of 5 years, except that the members first appointed shall serve staggered terms such that the terms of not more than 3 members expire at one time.

(4) INITIAL MEETING.—Not later than 30 days after the date on which a majority of the members have been appointed, the committee shall hold its first meeting.

(d) REPORTS.—Not later than 1 year after the date of the enactment of this part, and annually thereafter, the committee shall submit to the Congress, and make public, a report regarding—

(1) the extent to which persons required to comply with this part are cooperating in implementing the standards adopted under this part;

(2) the extent to which such entities are meeting the privacy and security standards adopted under this part and the types of penalties assessed for noncompliance with such standards;

(3) whether the Federal and State Governments are receiving information of sufficient quality to meet their responsibilities under this part;

(4) any problems that exist with respect to implementation of this part; and

(5) the extent to which timetables under this part are being met.

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * * * *

USE OF PUBLIC AGENCIES OR PRIVATE ORGANIZATIONS TO FACILITATE PAYMENT TO PROVIDERS OF SERVICES

SEC. 1816. (a) * * *

* * * * * * *

(l) No agency or organization may carry out (or receive payment for carrying out) any activity pursuant to an agreement under this section to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893.

FEDERAL HOSPITAL INSURANCE TRUST FUND

SEC. 1817. (a) * * *

* * * * * * *

(k) HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—

(1) ESTABLISHMENT.—There is hereby established in the Trust Fund an expenditure account to be known as the "Health Care Fraud and Abuse Control Account" (in this subsection referred to as the "Account").

(2) APPROPRIATED AMOUNTS TO TRUST FUND.—

(A) IN GENERAL.—There are hereby appropriated to the Trust Fund—

(i) such gifts and bequests as may be made as provided in subparagraph (B);

(ii) such amounts as may be deposited in the Trust Fund as provided in sections 242(b) and 249(c) of the Health Coverage Availability and Affordability Act of 1996, and title XI; and

(iii) such amounts as are transferred to the Trust Fund under subparagraph (C).

(B) AUTHORIZATION TO ACCEPT GIFTS.—The Trust Fund is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Trust Fund, for the benefit of the Account or any activity financed through the Account.

(C) TRANSFER OF AMOUNTS.—The Managing Trustee shall transfer to the Trust Fund, under rules similar to the rules in section 9601 of the Internal Revenue Code of 1986, an amount equal to the sum of the following:

(i) Criminal fines recovered in cases involving a Federal health care offense (as defined in section 982(a)(6)(B) of title 18, United States Code).

(ii) Civil monetary penalties and assessments imposed in health care cases, including amounts recovered under titles XI, XVIII, and XIX, and chapter 38 of title 31, United States Code (except as otherwise provided by law).

(iii) Amounts resulting from the forfeiture of property by reason of a Federal health care offense.

(iv) Penalties and damages obtained and otherwise creditable to miscellaneous receipts of the general fund of the Treasury obtained under sections 3729 through 3733 of title 31, United States Code (known as the False Claims Act), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

(3) APPROPRIATED AMOUNTS TO ACCOUNT FOR FRAUD AND ABUSE CONTROL PROGRAM, ETC.—

(A) DEPARTMENTS OF HEALTH AND HUMAN SERVICES AND JUSTICE.—

(i) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund such sums as the Secretary and the Attorney General certify are necessary to carry out the purposes described in subparagraph (C), to be available without further appropriation, in an amount not to exceed—

(I) for fiscal year 1997, $104,000,000,

(II) for each of the fiscal years 1998 through 2003, the limit for the preceding fiscal year, increased by 15 percent; and

(III) for each fiscal year after fiscal year 2003, the limit for fiscal year 2003.

(ii) MEDICARE AND MEDICAID ACTIVITIES.—For each fiscal year, of the amount appropriated in clause (i), the following amounts shall be available only for the purposes of the activities of the Office of the Inspector General of the Department of Health and Human Services with respect to the medicare and medicaid programs—

(I) for fiscal year 1997, not less than $60,000,000 and not more than $70,000,000;

(II) for fiscal year 1998, not less than $80,000,000 and not more than $90,000,000;

(III) for fiscal year 1999, not less than $90,000,000 and not more than $100,000,000;

(IV) for fiscal year 2000, not less than $110,000,000 and not more than $120,000,000;

(V) for fiscal year 2001, not less than $120,000,000 and not more than $130,000,000;

(VI) for fiscal year 2002, not less than $140,000,000 and not more than $150,000,000; and

(VII) for each fiscal year after fiscal year 2002, not less than $150,000,000 and not more than $160,000,000.

(B) FEDERAL BUREAU OF INVESTIGATION.—There are hereby appropriated from the general fund of the United States Treasury and hereby appropriated to the Account for transfer to the Federal Bureau of Investigation to carry out the purposes described in subparagraph (C), to be available without further appropriation—

(i) for fiscal year 1997, $47,000,000;

(ii) for fiscal year 1998, $56,000,000;

(iii) for fiscal year 1999, $66,000,000;

(iv) for fiscal year 2000, $76,000,000;

(v) for fiscal year 2001, $88,000,000;

(vi) for fiscal year 2002, $101,000,000; and

(vii) for each fiscal year after fiscal year 2002, $114,000,000.

(C) USE OF FUNDS.—The purposes described in this subparagraph are to cover the costs (including equipment, salaries and benefits, and travel and training) of the administration and operation of the health care fraud and abuse control program established under section 1128C(a), including the costs of—

(i) prosecuting health care matters (through criminal, civil, and administrative proceedings);

(ii) investigations;

(iii) financial and performance audits of health care programs and operations;

(iv) inspections and other evaluations; and

(v) provider and consumer education regarding compliance with the provisions of title XI.

(4) APPROPRIATED AMOUNTS TO ACCOUNT FOR MEDICARE INTEGRITY PROGRAM.—

(A) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund for each fiscal year such amounts as are necessary to carry out the Medicare Integrity Program under section 1893, subject to subparagraph (B) and to be available without further appropriation.

(B) AMOUNTS SPECIFIED.—The amount appropriated under subparagraph (A) for a fiscal year is as follows:

(i) For fiscal year 1997, such amount shall be not less than $430,000,000 and not more than $440,000,000.

(ii) For fiscal year 1998, such amount shall be not less than $490,000,000 and not more than $500,000,000.

(iii) For fiscal year 1999, such amount shall be not less than $550,000,000 and not more than $560,000,000.

(iv) For fiscal year 2000, such amount shall be not less than $620,000,000 and not more than $630,000,000.

(v) For fiscal year 2001, such amount shall be not less than $670,000,000 and not more than $680,000,000.

(vi) For fiscal year 2002, such amount shall be not less than $690,000,000 and not more than $700,000,000.

(vii) For each fiscal year after fiscal year 2002, such amount shall be not less than $710,000,000 and not more than $720,000,000.

(5) ANNUAL REPORT.—The Secretary and the Attorney General shall submit jointly an annual report to Congress on the amount of revenue which is generated and disbursed, and the justification for such disbursements, by the Account in each fiscal year.

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PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

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USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) * * *

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(c)(1) * * *

* * * * * * *

(6) No carrier may carry out (or receive payment for carrying out) any activity pursuant to a contract under this subsection to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

* * * * * * *

(r) The Secretary shall establish a system which provides for a unique identifier for each physician who furnishes services for which payment may be made under this title. *Under such system, the Secretary may impose appropriate fees on such physicians to cover the costs of investigation and recertification activities with respect to the issuance of the identifiers.*

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PART C—MISCELLANEOUS PROVISIONS

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AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) * * *

* * * * * * *

(P) in the case of home health agencies which provide home health services to individuals entitled to benefits under this title who require catheters, catheter supplies, ostomy bags, and supplies related to ostomy car (described in section 1861(m)(5)), to offer to furnish such supplies to such an individual as part of their furnishing of home health services, [and]

(Q) in the case of hospitals, skilled nursing facilities, home health agencies, and hospice programs, to comply with the requirement of subsection (f) (relating to maintaining written policies and procedures respecting advance directives)[.]*; and*

(R) to contract only with a clearinghouse (as defined in section 1171) that meets each standard and implementation specification adopted or established under part C of title XI on or after the date on which the clearinghouse is required to comply with the standard or specification.

In the case of a hospital which has an agreement in effect with an organization described in subparagraph (F), which organization's contract with the Secretary under part B of title XI is terminated on or after October 1, 1984, the hospital shall not be determined to be out of compliance with the requirement of such subparagraph during the six month period beginning on the date of the termination of that contract.

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PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SEC. 1876. (a) * * *

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(i)(1) Each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that [the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the eligible organization involved as he may provide in regulations), if he finds that the organization—

[(A) has failed substantially to carry out the contract,

[(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section, or

[(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).] *in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—*

(A) has failed substantially to carry out the contract;

(B) is carrying out the contract in a manner substantially inconsistent with the efficient and effective administration of this section; or

(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).

* * * * * * *

(6)(A) * * *

(B) The remedies described in this subparagraph are—

(i) civil money penalties of not more than $25,000 for each determination under subparagraph (A) or, with respect to a determination under clause (iv) or (v)(I) of such subparagraph, of not more than $100,000 for each such determination, plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iv), $15,000 for each individual not enrolled as a result of the practice involved,

(ii) suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

(iii) suspension of payment to the organization under this section for individuals enrolled after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

[The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).**]**

(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1) the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

(i) Civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

(ii) Civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists.

(iii) Suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.

(D) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph

(B)(i) or (C)(i) in the same manner as such provisions apply to a civil money penalty or proceeding under section 1128A(a).

(7)(A) Each risk-sharing contract with an eligible organization under this section shall provide that the organization will maintain [an agreement] *a written agreement* with a utilization and quality control peer review organization (which has a contract with the Secretary under part B of title XI for the area in which the eligible organization is located) or with an entity selected by the Secretary under section 1154(a)(4)(C) under which the review organization will perform functions under section 1154(a)(4)(B) and section 1154(a)(14) (other than those performed under contracts described in section 1866(a)(1)(F)) with respect to services, furnished by the eligible organization, for which payment may be made under this title.

* * * * * * *

(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

(A) the Secretary first provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1) and the organization fails to develop or implement such a plan;

(B) in deciding whether to impose sanctions, the Secretary considers aggravating factors such as whether an organization has a history of deficiencies or has not taken action to correct deficiencies the Secretary has brought to the organization's attention;

(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.

* * * * * * *

MEDICARE INTEGRITY PROGRAM

SEC. 1893. (a) ESTABLISHMENT OF PROGRAM.—There is hereby established the Medicare Integrity Program (in this section referred to as the "Program") under which the Secretary shall promote the integrity of the medicare program by entering into contracts in accordance with this section with eligible private entities to carry out the activities described in subsection (b).

(b) ACTIVITIES DESCRIBED.—The activities described in this subsection are as follows:

(1) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans,

including equipment and software technologies which surpass the capability of the equipment and technologies used in the review of claims under this title as of the date of the enactment of this section).

(2) Audit of cost reports.

(3) Determinations as to whether payment should not be, or should not have been, made under this title by reason of section 1862(b), and recovery of payments that should not have been made.

(4) Education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

(5) Developing (and periodically updating) a list of items of durable medical equipment in accordance with section 1834(a)(15) which are subject to prior authorization under such section.

(c) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if—

(1) the entity has demonstrated capability to carry out such activities;

(2) in carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General of the United States, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this title and in other cases arising out of such activities;

(3) the entity demonstrates to the Secretary that the entity's financial holdings, interests, or relationships will not interfere with its ability to perform the functions to be required by the contract in an effective and impartial manner; and

(4) the entity meets such other requirements as the Secretary may impose.

In the case of the activity described in subsection (b)(5), an entity shall be deemed to be eligible to enter into a contract under the Program to carry out the activity if the entity is a carrier with a contract in effect under section 1842.

(d) PROCESS FOR ENTERING INTO CONTRACTS.—The Secretary shall enter into contracts under the Program in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

(1) The Secretary shall determine the appropriate number of separate contracts which are necessary to carry out the Program and the appropriate times at which the Secretary shall enter into such contracts.

(2)(A) Except as provided in subparagraph (B), the provisions of section 1153(e)(1) shall apply to contracts and contracting authority under this section.

(B) Competitive procedures must be used when entering into new contracts under this section, or at any other time considered appropriate by the Secretary, except that the Secretary may contract with entities that are carrying out the activities described in this section pursuant to agreements under section

1816 or contracts under section 1842 in effect on the date of the enactment of this section.

(3) A contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

(e) LIMITATION ON CONTRACTOR LIABILITY.—The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1157.

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TITLE 18, UNITED STATES CODE

CHAPTER 1—GENERAL PROVISIONS

Sec.
1. Repealed.
2. Principals.

* * * * * * *

24. Definition of Federal health care offense.

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§ 24. Definition of Federal health care offense

(a) As used in this title, the term "Federal health care offense" means a violation of, or a criminal conspiracy to violate—

(1) section 669, 1035, or 1347 of this title; or

(2) section 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of this title, if the violation or conspiracy relates to a health care benefit program.

(b) As used in this title, the term "health care benefit program" has the meaning given such term in section 1347(b) of this title.

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CHAPTER 31—EMBEZZLEMENT AND THEFT

Sec.
641. Public money, property or records.

* * * * * * *

669. Theft or embezzlement in connection with health care.

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§ 669. Theft or embezzlement in connection with health care

(a) Whoever embezzles, steals, or otherwise without authority willfully and unlawfully converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health care benefit program, shall be fined under this title or imprisoned not more than 10 years, or both; but if the value of such property does not exceed the sum of $100 the defendant shall be fined under this title or imprisoned not more than one year, or both.

(b) As used in this section, the term "health care benefit program" has the meaning given such term in section 1347(b) of this title.

* * * * * * *

CHAPTER 46—FORFEITURE

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§ 982. Criminal forfeiture

(a)(1) The court, in imposing sentence on a person convicted of an offense in violation of section 5313(a), 5316, or 5324 of title 31, or of section 1956, 1957, or 1960 of this title, shall order that the person forfeit to the United States any property, real or personal, involved in such offense, or any property traceable to such property. However, no property shall be seized or forfeited in the case of a violation of section 5313(a) of title 31 by a domestic financial institution examined by a Federal bank supervisory agency or a financial institution regulated by the Securities and Exchange Commission or a partner, director, or employee thereof.

* * * * * * *

(6) The court, in imposing sentence on a person convicted of a Federal health care offense, shall order the person to forfeit property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.

(b)(1) Property subject to forfeiture under this section, any seizure and disposition thereof, and any administrative or judicial proceeding in relation thereto, shall be governed—

(A) in the case of a forfeiture under subsection (a)(1) *or (a)(6)* of this section, by subsections (c) and (e) through (p) of section 413 of the Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. 853); and

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CHAPTER 47—FRAUD AND FALSE STATEMENTS

Sec.
1001. Statements or entries generally.
* * * * * * *
1035. False statements relating to health care matters.
* * * * * * *

§ 1035. False statements relating to health care matters

(a) Whoever, in any matter involving a health care benefit program, knowingly—

(1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or

(2) makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry,

in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 5 years, or both.

(b) As used in this section, the term "health care benefit program" has the meaning given such term in section 1347(b) of this title.

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CHAPTER 63—MAIL FRAUD

§ 1345. Injunctions against fraud

(a)(1) If a person is—

(A) violating or about to violate this chapter or section 287, 371 (insofar as such violation involves a conspiracy to defraud the United States or any agency thereof), or 1001 of this title; [or]

(B) committing or about to commit a banking law violation (as defined in section 3322(d) of this title), *or*

(C) committing or about to commit a Federal health care offense.

the Attorney General may commence a civil action in any Federal court to enjoin such violation.

(2) If a person is alienating or disposing of property, or intends to alienate or dispose of property, obtained as a result of a banking law violation (as defined in section 3322(d) of this title) *or a Federal health care offense* or property which is traceable to such violation, the Attorney General may commence a civil action in any Federal court—

(A) to enjoin such alienation or disposition of property; or

(B) for a restraining order to—

(i) prohibit any person from withdrawing, transferring, removing, dissipating, or disposing of any such property or property of equivalent value; and

(ii) appoint a temporary receiver to administer such restraining order.

* * * * * * *

§ 1347. Health care fraud

(a) Whoever knowingly executes, or attempts to execute, a scheme or artifice—

(1) to defraud any health care benefit program; or

(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program;

in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365 of this title), such person shall be fined under this title or imprisoned not more than 20 years, or both; and if the violation results in death, such person shall be

fined under this title, or imprisoned for any term of years or for life, or both.

(b) As used in this section, the term "health care benefit program" means any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract.

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CHAPTER 73—OBSTRUCTION OF JUSTICE

Sec.
1501. Assault on process server.

* * * * * * *
1518. Obstruction of criminal investigations of health care offenses.

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§ 1510. Obstruction of criminal investigations

(a) * * *

(b)(1) Whoever, being an officer of a financial institution, with the intent to obstruct a judicial proceeding, directly or indirectly notifies any other person about the existence or contents of a subpoena for records of that financial institution, or information that has been furnished to the grand jury in response to that subpoena, shall be fined under this title or imprisoned not more than 5 years, or both.

* * * * * * *

(3) As used in this subsection—

(A) the term "an officer of a financial institution" means an officer, director, partner, employee, agent, or attorney of or for a financial institution; and

(B) the term "subpoena for records" means a Federal grand jury subpoena *or a Department of Justice subpoena (issued under section 3486 of title 18),* for customer records that has been served relating to a violation of, or a conspiracy to violate—

(i) section 215, 656, 657, 1005, 1006, 1007, 1014, 1344, 1956, 1957, or chapter 53 of title 31; or

(ii) section 1341 or 1343 affecting a financial institution.

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§ 1518. Obstruction of criminal investigations of health care offenses

(a) Whoever willfully prevents, obstructs, misleads, delays or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of a Federal health care offense to a criminal investigator shall be fined under this title or imprisoned not more than 5 years, or both.

(b) As used in this section the term "criminal investigator" means any individual duly authorized by a department, agency, or armed

force of the United States to conduct or engage in investigations for prosecutions for violations of health care offenses.

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CHAPTER 95—RACKETEERING

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§ 1956. Laundering of monetary instruments

(a) * * *

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(c) As used in this section—

(1) * * *

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(7) the term ''specified unlawful activity'' means—

(A) * * *

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(F) Any act or activity constituting an offense involving a Federal health care offense.

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CHAPTER 223—WITNESSES AND EVIDENCE

Sec.

3481. Competency of accused.

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3486. Authorized investigative demand procedures.

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§ 3486. Authorized investigative demand procedures

(a) AUTHORIZATION.—In any investigation relating to any act or activity involving a Federal health care offense, the Attorney General or the Attorney General's designee may issue in writing and cause to be served a subpoena requiring the production of any records (including any books, papers, documents, electronic media, or other objects or tangible things), which may be relevant to an authorized law enforcement inquiry, that a person or legal entity may possess or have care, custody, or control. A subpoena shall describe the objects required to be produced and prescribe a return date within a reasonable period of time within which the objects can be assembled and made available.

(b) SERVICE.—A subpoena issued under this section may be served by any person designated in the subpoena to serve it. Service upon a natural person may be made by personal delivery of the subpoena to him. Service may be made upon a domestic or foreign corporation or upon a partnership or other unincorporated association which is subject to suit under a common name, by delivering the subpoena to an officer, to a managing or general agent, or to any other agent authorized by appointment or by law to receive service of process. The affidavit of the person serving the subpoena entered on a true copy thereof by the person serving it shall be proof of service.

(c) ENFORCEMENT.—In the case of contumacy by or refusal to obey a subpoena issued to any person, the Attorney General may invoke the aid of any court of the United States within the jurisdiction of which the investigation is carried on or of which the subpoenaed person is an inhabitant, or in which he carries on business or may be found, to compel compliance with the subpoena. The court may issue an order requiring the subpoenaed person to appear before the Attorney General to produce records, if so ordered, or to give testimony touching the matter under investigation. Any failure to obey the order of the court may be punished by the court as a contempt thereof. All process in any such case may be served in any judicial district in which such person may be found.

(d) IMMUNITY FROM CIVIL LIABILITY.—Notwithstanding any Federal, State, or local law, any person, including officers, agents, and employees, receiving a summons under this section, who complies in good faith with the summons and thus produces the materials sought, shall not be liable in any court of any State or the United States to any customer or other person for such production or for nondisclosure of that production to the customer.

(e) LIMITATION ON USE.—(1) Health information about an individual that is disclosed under this section may not be used in, or disclosed to any person for use in, any administrative, civil, or criminal action or investigation directed against the individual who is the subject of the information unless the action or investigation arises out of and is directly related to receipt of health care or payment for health care or action involving a fraudulent claim related to health; or if authorized by an appropriate order of a court of competent jurisdiction, granted after application showing good cause therefor.

(2) In assessing good cause, the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services.

(3) Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

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APPENDIX

HAY/HUGGINS COMPANY, INC,
Washington, DC, March 15, 1996.

Dr. BETH FUCHS,
Congressional Research Service,
Library of Congress, Washington, DC.

DEAR BETH: As you requested, we have reviewed the group-to-individual conversion section language in H.R. 3070 as of March 14, 1996. We believe that there would be no significant difference in cost between that provision and the one contained in S. 1028 that we evaluated in our report of February 21, 1996.

H.R. 3070 would require that each insurer offer "qualifying coverage" to "qualifying individuals" unless the State implemented programs that would meet the goals of the proposal. The insurer is required to offer at least one plan that would have an actuarial value not less than the average plan provided by the insurer or in the State. This differs from S. 1028 which requires that all policies issued by the insurer be offered on a guaranteed insurance basis to qualifying individuals.

The important point, from a cost perspective, is that there is no limit on the premium that could be charged for the qualifying insurance. Therefore, insurers would be free to charge the amount needed to cover the health benefits costs of the qualifying individuals and there would be no increase in cost to any other segment of the market.

If a State were to place limits on the premium that could be charged, then there would be an additional cost. In absence of any other requirement in the State, the insurer would have to shift that cost to other policyholders.

While the mechanism would be different from S. 1028, we believe the cost impact would be the same. Using our earlier example, if the premium for qualifying individuals were limited to 200 percent of the group premium then premiums for other individual policyholders would eventually increase by 1 to 3 percent.

Sincerely,

EDWIN C. HUSTEAD,
Senior Vice President.

MINORITY VIEWS ON H.R. 3070

This Congress once again has an opportunity to exercise leadership in health policy by enacting legislation with the sole purpose of meeting the health needs and concerns of American families. The legislation the Committee reports to the House today proposes only very modest insurance reforms. If this legislation were enacted, in its current form, we would offer at least a modicum of security to working Americans by ensuring that they could continue health insurance coverage without incurring new waiting periods or penalties for pre-existing conditions.

We therefore are pleased with the direction in which the Committee is moving. This kind of legislation can be passed by the House with strong bipartisan support, including the support of Members of this Committee who have endorsed much more comprehensive and fundamental health reform. Because similar legislation in the Senate authored by Senators Kassebaum and Kennedy has garnered considerable bipartisan support, the final outcome should look promising indeed. Alas, the Republican leadership appears determined to prevent that from happening.

The best evidence of the leadership's intentions comes from their decision on the markup vehicle itself. Rather than considering the House companion to the Kassebaum legislation, a bill introduced by Republican Representative Roukema, the Committee was directed by the Republican health care task force to consider a less comprehensive and less generous bill. The Democratic Members of the Committee offered an amendment in the nature of a substitute that would bring the House Republicans' bill closer to the Kassebaum-Roukema legislation in several critical respects, but that amendment was defeated by a party line vote.

Meanwhile, several other Committees are in the process of preparing legislation that the Republican leadership does not hesitate to tout as part of an omnibus health package to be combined with the Commerce Committee's bill. It appears that this package of "reforms" will be assembled by the Committee on Rules and brought to the House floor within only a few days. Sadly, the generally positive approach developed in the Commerce Committee and supported by much of this Committee's membership will be buried under an avalanche of highly controversial, special-interest provisions.

We issued a challenge to the Republican leadership during the Subcommittee markup to renounce this cynical and self-defeating tactic. We were disappointed by their failure to do so. In contrast to the kind of special interest free-for-all commenced by the Republicans, we Democrats offered and supported a series of amendments that would correct several flaws in this bill. For example, Democratic amendments (some included in the amendment in the nature of a substitute) would have ensured that (1) no State laws moving

further in health insurance reform would be pre-empted; (2) eligible individuals entering the individual market would be able to select from a variety of insurance plans, rather than be relegated to a single plan providing an "actuarially average" benefits package; (3) the ability to purchase group policies would be ensured for all business, not just the smallest ones; (4) group policies could not include premium contribution requirements based on health status or pre-existing conditions; and (5) small companies would be able to join together to form purchasing groups. All of these provisions are included in both the Kassebaum and the Roukema bills. They were excluded by the Republicans from this legislation because they were opposed by the most retrograde elements of the health insurance industry. The changes proposed by Democrats would have made the legislation stronger and more responsive to the needs and concerns of our citizens, without unduly burdening insurers or threatening their financial viability. Furthermore, these changes would have facilitated ultimate House-Senate agreement by bringing the House bill closer to the Senate legislation. Nevertheless, these amendments too were defeated on party-line votes.

Although many of the bill's provisions on fraud and abuse are praiseworthy, some are not. Democratic Members offered amendments to undo some of the damage to the federal government's ability to protect taxpayer dollars. For example, the Republican bill gives negligent providers a free pass when their claims for reimbursement from Medicare and Medicaid turn out to be false. Democrats tried, unsuccessfully, to retain provisions of existing law that place the risk of bad claims not on taxpayers, but on providers, where it belongs. Similarly, this bill creates a loophole in the prohibition against kickbacks to doctors who refer Medicare or Medicaid business. The Inspector General of the Department of Health and Human Services, the Department of Justice, and the General Accounting Office all expressed grave concern that this Republican provision would cripple enforcement, but Democratic efforts to maintain existing law again failed. Finally, the bill imposes an unprecedented requirement on the Secretary to provide advisory opinions upon request concerning specific applications of the intent-based criminal kickback statute. This, too, threatens to undermine protections against fraud, waste, and abuse of taxpayer dollars, according to the Inspector General, the Department of Justice, and the General Accounting Office. But again, Democratic efforts to remove the offending language, replacing it with non-harmful interpretive rulings—exactly the language that had been agreed to in the House-Senate conference report on H.R. 2491—were rejected. In sum, in all three instances, the taxpayer lost; and well-connected providers won.

In spite of the flaws in the Committee bill, we would have refrained from proposing amendments if it were clear that this Committee's legislation were indeed destined to be the health insurance reform vehicle the House will consider. We know, however, that this is not what the Republican leadership intends. They plan to load this bill down with controversial legislation from other committees, addressing medical savings accounts, medical malpractice, antitrust immunity for certain providers, and an assortment of other bells and whistles to benefit insurers, doctors, hospitals, and

other wealthy and powerful interests. Thus, we thought it appropriate to show the American people the other side of the coin—the kinds of benefits that such legislation might offer to average citizens, not just the special interests. We were particularly disappointed that Republican Members voted to continue allowing insurance companies to deny coverage to breast cancer patients for medically indicated bone marrow treatment which physicians had determined would save their patients' lives, and to deny doctors the right to decide—without improper meddling from the insurance company—when it is medically appropriate for new mothers and their babies to leave the hospital after a birth.

With respect to such proposals, we fully recognize—as the Committee leadership and the Democratic leadership have emphasized—the importance of keeping their legislation narrowly focused to avoid controversy and facilitate passage. We respect this desire and continue to hope that the Republican leadership will recognize the wisdom of that course and follow it. They know, and this Committee's majority know, that the package they plan to construct in the Rules Committee cannot and will not become law. Thus, the promise of this Committee's action is destined never to be fulfilled. While that realization disappoints us, the greatest disappointment will be the dashed hopes of working Americans who believe we should enact honest insurance reform.

This Committee can and should seize this moment. We can and should stand up for working Americans. We can and should insist that the House consider this modest, uncomplicated piece of legislation which, while it is not everything many would like, nonetheless helps a significant number of working American families. This Committee should firmly and courageously resist attempts to muddy the waters and sink the ship by loading this important bill with deadly ballast.

JOHN D. DINGELL.
HENRY A. WAXMAN.
EDWARD J. MARKEY.
CARDISS COLLINS.
BILL RICHARDSON.
JOHN BRYANT.
RICK BOUCHER.
THOMAS J. MANTON.
EDOLPHUS TOWNS.
GERRY E. STUDDS.
FRANK PALLONE Jr.
SHERROD BROWN.
ELIZABETH FURSE.
PETER DEUTSCH.
BOBBY L. RUSH.
ANNA G. ESHOO.
RON KLINK.
BART STUPAK.

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